HEALTH in BERKSHIRE 1964–1965

The report of the
COUNTY MEDICAL OFFICER
and
PRINCIPAL SCHOOL MEDICAL OFFICER
for 1964 and 1965

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INTRODUCTION

Custom and statutory duty both oblige a Medical Officer of Health to present to his Council an annual report on the state of health in the administrative area. New thinking and major schemes rarely progress from conception to realisation within one calendar year however. Coupled with this many Medical Officers find that unless a report is little more than a collection of statistical tables its annual preparation involves time of senior staff which might be used more profitably. For these reasons I have continued my predecessor's practice and have combined reports for 1964 and 1965.

The National Health Service

The services provided through the Health Committee are one arm of the National Health Service: they also dovetail with provision for the schoolchild made through the Education Committee and with facilities for the handicapped and care of the elderly under the Welfare Services Committee. All working in any part of the Health, Welfare and Social Services must always remember that his contribution forms part of a greater whole. This report again includes that as Principal School Medical Officer, but does not cover services under the Welfare Services Committee.

The tripartite structure of the Health Service has frequently been criticised. The existence of three responsible authorities with overlapping catchment areas make effective overall planning a near impossibility. The exchange of 10 year plans and the opportunity of commenting on or discussing them at joint meetings is an important and welcome step forward: it does not, however, meet the need for joint planning of the full range of services throughout one area. Liaison over day-to-day provision in this region is excellent, but it must be irritating to consultants and hospital staff to have to deal with several local health authorities and it is time-consuming for us to liaise with different groups of consultants and at least eight Hospital Management Committees. Not only varying areas but also differing methods of finance prove obstacles. Even if it can be shown that the expenditure of a modest sum in prevention may ultimately yield bigger savings in cost of treatment, someone inevitably asks "why should the ratepayer pay instead of the Health Service—we all pay our stamps?". The "stamp" mainly goes towards insurance benefits: the cost of the hospital and Executive Council services (as well as approximately half our own services) is largely raised nationally from direct or indirect taxation. Most families pay both rates and taxes: surely most breadwinners would prefer the Treasurer to take an extra coin from his trouser pocket if this meant the Chancellor taking a note less from his wallet. It is to the credit of the Council that, although fully aware of these problems, this has not yet resulted in any serious hold up in developments.

Priorities

The Minister of Health has set out clearly his priorities within the National Health Service. These are:

(1) to promote health and to forestall illness and disability by preventive measures
(2) the provision of treatment or long-term care in the patient's own home or in the community where illness or disability nevertheless occurs
(3) treatment or care in hospital only where specialist treatment or continuous nursing care is required.

We can no longer think of the first of these functions being exclusively the job of the local authority, the second of the general practitioner or the

third as the only role of hospitals. The general practitioner of today sees himself as having a responsibility for complete family care, including prevention. One has but to mention the maternity services, psychiatry, paediatrics and geriatrics to appreciate the essential contributions to prevention and community care being made by hospital colleagues.

Liaison

The Council will not need reminding that Berkshire is now the most rapidly growing county. Births have been twice as numerous as deaths since 1960. Inward migration accounts for an even bigger increase and, since those coming in are frequently young couples setting up home, the rapid increase in births is likely to be accentuated for some years to come. Our efforts in the past two years have been directed at gearing developments to keep pace with the expected growth in the county, and secondly to establishing closer working with colleagues in other branches of the health service. The Council's attention is particularly drawn to the report on pages 18–21 which describes the scheme of attachment of health visitors and nursing staff to general practices. Starting in early 1964 as an experiment in one or two areas, the undoubted benefits of the scheme led to its acceptance in principle and to its extension to cover some 146 of staff by the end of 1965. It is hoped that before the end of 1966 the whole county will be covered, and that we shall have started experimental workings with neighbouring authorities across county boundaries. As examples of closer links with hospital colleagues may be cited secondment of health visitors to liaise with the premature baby unit in Reading and others to link with geriatricians in East and in North Berks, the joint appointment of psychiatric social workers and the expansion of the occupational therapy services with plans for the therapists to work closely with departments of physical medicine.

Health Education

This is our most important weapon in the promotion of health. During 1965 the Health Committee agreed in principle it was desirable to appoint a Health Education Officer, but decided not to ask for the post to be established in 1966–67 in the light of financial conditions. Within the Health Department we regarded this as top priority and arrangements were therefore made to enable one of the Area Nursing Officers to devote herself exclusively to this task. The Health Committee devoted considerable thought to the future pattern of work in child health centres as a result of which they are likely to lose the more traditional pattern as being places where babies are weighed and foods are sold, and more as centres for advice and teaching and for watching development of the child through its pre-school years.

With the encouragement of the Education Committee a good start has been made with the provision of an audiology service, and it is hoped to commence routine sweep testing of children in their second year at primary school during 1966.

Following a successful experimental scheme at Wantage, the Health Committee hopes to extend facilities for the taking of cervical smears (subject only to availability of laboratory facilities) in most areas of the county during the coming year.

In the mental health field we still have much leeway to make up. Close association with the Education Committee has led to interesting developments with South Field Hostel, Wokingham and with Bennett House School, Abingdon. Our most urgent need is for additional school provision for mentally handicapped children in East Berks and for the new school and hostel at Newbury. For the adult mentally handicapped no purpose-built workshop

is yet in sight, and progress on the first hostel at Bracknell has met with frustrating delays.

Dental Health

Mr. Jacob's report as Principal School Dental Officer appears on page 39.

Fluoridation was again under consideration throughout both years. The Health Committee had decided not to make a further approach to the County Council until the result of the Watford case was known, and I was asked to submit a comprehensive report. This report was submitted to the committee in November, 1964 and concluded with the following summary:

(1) Children brought up in areas where the water supply contains fluoride levels of about 1 p.p.m. suffer only about half the caries experienced by children from low fluoride areas.
(2) Adding fluoride to water supplies deficient in fluoride produces similar dental benefits.
(3) Despite intensive and geographically widespread investigations no evidence has emerged of any risk to health in areas where the water supply has always contained 1 p.p.m. of fluoride, or in fluoridation study areas.
(4) The beneficial effect of fluorides appears to be independent of equally beneficial effects of good diet and dental hygiene. No other method so far suggested is either as effective, reliable or as safe as supplementing levels of fluorine in domestic water supplies.
(5) The question of legal powers will be settled by Court ruling.
(6) In considering ethical issues one must weigh the considerable dental benefits to coming generations against the feelings of relatively few—however strongly and however genuine their objections may be held.
(7) The addition of fluoride presents no more problems to water engineers than the adding of numerous other chemicals in the various treatment processes already used. No reliable estimate of cost has been attempted for Berkshire at this stage.

The Health Committee decided to seek further information regarding the decisions of adjoining authorities and also asked for an estimate of cost in Berkshire. By the time this matter was reconsidered in October, 1965 it was known that the Watford case had been withdrawn. Precise estimates of cost were difficult to make without involving Water Boards in a considerable amount of work but it was thought unlikely that this would be more than 1s. 0d. per head of population per annum at the outside. The committee also noted that the ultimate county-wide cost of the order of £25,000 per annum was unlikely to be attained within ten years. Following consideration of these further reports the Health Committee recommended the Council to approve in principle the addition of fluoride to water supplies in the county which are naturally deficient in this element and the making of appropriate arrangements with local water undertakings. The County Council rejected the Health Committee recommendation.

Staff

After serving Berkshire for 25 years, Dr. Waudby-Smith retired in September, 1964, but unfortunately his state of health did not allow him to enjoy a long retirement. Dr. Hunt was promoted to the post of Deputy County Medical Officer, and was succeeded as Senior Medical Officer (School Health) by Dr. Cima. We were sorry to lose Dr. Camm, Medical Officer of Health, Maidenhead, who went to the North East Metropolitan Regional Hospital Board, and Dr. Brearley, Medical Officer of Health, Easthampstead

Rural District Council, who moved to North Oxfordshire. We were pleased to welcome Mr. Parkin as the department's first Administrative Officer, an appointment which quickly proved its worth. The end of an era in the Departments' administration was marked by the retirement in 1964 both of the Chief Clerk, Mr. Burt, who had joined the department in 1920, and of Mr. Hopkins, Section Head, School Health, who had served for just over 50 years.

Mr. Lansdown relinquished the chairmanship of the Health Committee in May, 1965 having held this for 17 years since the beginning of the health service in 1948. Members will know better than I of the work he put in during these years, but I am personally grateful to him for the very considerable amount of help given to me during my first year or two of office. We were delighted to have Mr. Arbuthnott elected to the chairmanship.

Although members feel progress is slow in certain directions, very real progress has been made during 1964 and 1965. These developments are the results of efforts by the chairman and members, by the many staff in this and other departments and working in various parts of the county, not to mention a very large number of voluntary workers who assist in so many ways. Our thanks are due to them all.

D. E. CULLINGTON,

County Medical Officer and
Principal School Medical Officer

JULY, 1966

VITAL STATISTICS

Population

The population continues to rise consistently every year. The Registrar General estimated the resident mid year population for 1965 to have been 447,950 compared with 432,690 in 1964 and 417,360 in 1963. Indeed the population change in Berkshire during the period 1959–64 was higher than in any other county at + 18·3%.

Population figures for the urban and rural districts are given in Table One in the Appendix.

Births

The number of births assigned to the county was 9,280 in 1965 (4,786 males and 4,494 females). The numbers of live births for urban and rural districts are given in Table One in the Appendix.

There were 525 illegitimate births during this same year (including 8 stillbirths). More information on births is given in Table Two in the Appendix.

Deaths

The total number of deaths in 1965, after adjusting for inward and outward transferable deaths, was 4,015 compared with 3,843 in 1964. The crude death rate per 1,000 population was 8·9 in both years.

In 1965 the main causes of death were:

Diseases of the heart and circulation	(36·2 per cent of total)
Malignant neoplasms	(19·2 per cent of total)
Vascular diseases of nervous system	(14·5 per cent of total)
Diseases of respiratory system	(6·1 per cent of total)

A full list of the causes of death can be found in Table Three in the Appendix.

Summary

Area of Administrative County	454,725 acres	
Population (1961 Census)	384,217	
	1964	*1965*
Population (Mid year estimate)	432,690	447,950
Live births – number	8,921	9,280
– rate per 1,000 population	20·6	20·7
Illegitimate live births (per cent total live births)	5·1	5·5
Still births – number	116	113
– rate per 1,000 total live and stillbirths	12·8	12·0
Total live and stillbirths	9,037	9,393
Infant deaths (deaths under one year)	143	128
Infant mortality rates		
Total infant deaths per 1,000 total live births	16·0	13·7
Legitimate infant deaths per 1,000 legitimate live births	15·9	13·4
Illegitimate infant deaths per 1,000 illegitimate live births	17·4	19·3
Neo-natal mortality rate		
Deaths under 4 weeks per 1,000 total live births	10·9	10·2
Early neo-natal mortality rate		
Deaths under one week per 1,000 total live births	9·5	8·7
Perinatal mortality rate		
Stillbirths and deaths under 1 week per 1,000 total live and stillbirths	22·2	20·6

Maternal mortality (including abortion)		
Number of deaths	2	1
Rate per 1,000 total live and stillbirths	0·2	0·1
Deaths		
Death rate per 1,000 population	8·9	8·9
Total number of deaths	3,843	4,015

INFECTIOUS DISEASES

Notifications

The following diseases were notified during the years 1964 and 1965. Full details of the diseases notified in each of the urban and rural districts are contained in Table Four in the appendices.

	1964	*1965*
Dysentery	86	359
Encephalitis (post-infectious)	2	1
Erysipelas	16	15
Food poisoning	11	33
Malaria	2	—
Measles	1,689	6,811
Meningococcal infection	4	2
Ophthalmia neonatorum	1	—
Paratyphoid fever	4	5
Pneumonia	45	38
Puerperal pyrexia	18	11
Scarlet fever	86	136
Tuberculosis (respiratory)	137	110
Tuberculosis (non-respiratory)	16	20
Typhoid fever	1	2
Whooping cough	421	160

It is interesting to note that there were no notified cases of diphtheria or poliomyelitis in the county during these two years.

Once again measles was responsible for the majority of notified cases and 1965, like 1963, was an epidemic year for this disease. It is a disorder of childhood, the majority of children being under the age of seven years, and the cases were invariably mild. Considerable progress has now been made with the preparation of a measles vaccine and trials of various types of the vaccine were carried out in several parts of the country during these two years. It is anticipated that a vaccine will be available for use during 1966.

Tuberculosis

There were 120 primary notifications of tuberculosis during the year (110 respiratory and 10 non-respiratory). Eighteen deaths occurred as a result of this disease (all respiratory). I am grateful to the three Chest Physicians in the county for the following reports in connection with their clinic work in Central and West Berks, East Berks and North Berks.

Dr. G. H. Shaw, Consultant Chest Physician at the Central Chest Clinic, Reading, reports as follows:—

The Berkshire section of the Central Chest Clinic serves an estimated population of over 225,000. Clinic sessions are held at the Central Chest Clinic, Battle Hospital, Reading, Wantage Hospital, Wantage; Greenham House, Newbury and The Health Centre, Faringdon.

The number of notified cases on the clinic register fell during 1965 from 1,188 to 901 and the new notifications fell from 86 to 67.

58 cases of tuberculosis were known to have been bacteriologically positive during the year, including those patients positive whilst in hospital. 672 tuberculin negative reactors were vaccinated during the year.

The Medical Social Worker at the Central Chest Clinic reports:—

Since the last report the name "Almoner" has been changed nationally to Medical Social Worker, the new name being thought to be more descriptive of the work being done and more in keeping with the present day terminology. In 1964 and 1965 the number of patients helped by the Medical Social Worker and the sort of problems which they presented were similar to those of past years. Once again, patients with a diagnosis of pulmonary tuberculosis represented about half of the cases referred to the Medical Social Worker.

Most of the patients who had an employment problem were later resettled in suitable jobs by their former employers, either as the result of an approach to them by the patient himself, or by the Medical Social Worker, on his behalf. Others found work elsewhere on their own initiative or with the Disablement Resettlement Officer's help. There remain a few who cannot be found suitably light full-time work, and many not registered for work but who could do a few hours a day in a sheltered workshop or at an occupational centre, if such facilities existed in the county.

Now that many patients with chronic bronchitis attend the clinic at intervals of six months or more, their need for help may arise some time before the Medical Social Worker next sees them. To ensure that they receive help when it is most needed, the Medical Social Worker is glad to visit chest patients at any time at the request of the patient or his doctor. She can be contacted by telephone in the mornings at Battle Hospital, Reading 50481, extension 288.

Dr. B. C. Thompson, the Consultant Physician in charge at the Chest Clinic, Upton Hospital, Slough, reports as follows:—

The decline in incidence of tuberculosis has been, to some extent, checked by the increase in immigrants—especially from the Indian Sub-Continent. Some of these individuals bring tuberculosis in with them and spread it to their fellow Nationals by reason of their crowded living conditions here; others acquire tuberculosis after arrival in this country, from other sources. The actual size of this problem is difficult to assess but it is likely that somewhere between a quarter and a fifth of new cases lies in this population group.

The results of treatment are very good, and the immigrants make good patients—once they understand what they should do. There is a real difficulty in communication, so many of them having poor understanding of English. A further difficulty is their tendency to move from place to place, and it is difficult to keep in touch with them. The tracing of contacts in immigration groups is also difficult because of movement, and even in identification by name—as they tend to change their identifying name, or so it appears to us.

With the decline in tuberculosis the Chest Clinic service now undertakes an increasing amount of non-tuberculous chest disease—notably bronchitis, asthma and lung cancer. These conditions can be very time consuming but, in the case of the two former, at least the work is rewarding and can probably be better handled in our service than elsewhere, owing to the centralisation of equipment for medical assessment and also to our facilities for environmental care. Chronic non-tuberculous chest disease is common in immigrants and often difficult to handle—for the same reasons as those given above.

B.C.G. vaccination on a nation wide scale continues to be necessary so long as tuberculosis may exist undetected in the community, and especially until tuberculosis in immigrants comes under control. All tuberculin-positive

children found from the school B.C.G. programme who are referred to our Clinics are X-rayed, followed-up and, in many cases, given ambulant chemotherapy, even when no lesion is seen but a recent tuberculous infection suspected. The family and close contacts of all tuberculin-positive school children are regarded as tuberculosis contacts, and are submitted to routine examination here.

Dr. F. Ridehalgh, Consultant Chest Physician at The United Oxford Hospitals, reports as follows:—

Chest Clinic sessions have been held weekly throughout the year at Abingdon Hospital. The Health Visitor and the Medical Social Worker attend these sessions so that full co-ordination of clinical, preventive and socio-medical work is assured. I wish to note specially the tremendous effort, in her spare time, which Miss Almblad, the Health Visitor, devoted to fund raising for the Berkshire Care Committee, who, as usual, have been most helpful to our patients.

Analysis of weekly returns of tuberculous notifications for the Abingdon rural area (excluding Faringdon) show 16 notifications of tuberculosis (all forms) during 1965. Of these 13 were respiratory (eight male and five female).

In addition to the active cases formally notified, a further 17 cases of apparently inactive tuberculosis have come under supervision during the year. 159 new contacts have been examined and B.C.G. was given to 130 contacts.

IMMUNISATION AND VACCINATION

The Council's scheme provides for vaccination against smallpox, diphtheria, whooping cough, tetanus and poliomyelitis. Protection is offered to persons in the various eligible age groups at County Council clinics and through family doctors.

Vaccinations Undertaken

	Completed Primary Courses.		*Reinforcing Vaccinations*	
	1964	*1965*	*1964*	*1965*
Smallpox	5,620	6,950	2,739	1,026
Diphtheria	9,160	7,725	6,280	12,691
Whooping Cough ..	8,794	7,487	5,738	6,812
Tetanus	8,450	7,557	5,636	12,630
Poliomyelitis ..	8,440	9,341	5,576	5,626

Tetanus Immunisation

Routine protection against tetanus is necessary for all children, especially those living in a rural community. Immunisation should prevent death from casual infections and will remove the necessity to give anti-toxin if any person sustains a wound likely to give rise to tetanus. The anti-toxin treatment may give rise to serum reaction in children sensitive to horse serum and the immunity conferred by the anti-toxin is very short lived. Active immunisation with the tetanus toxoid, however, will obviate these dangers and provide immunity for a period of many years.

It is now usual to offer babies tetanus toxoid in the form of the triple antigen and to give a booster dose of "triple" at eighteen months and one of toxoid at the age of five years with the diphtheria toxoid. Older children can be given a primary course of three injections of tetanus toxoid and a reinforcing injection five years later.

Triple Immunisation

Triple vaccine protects against diphtheria, whooping cough and tetanus and is in use at the clinics and is also used by the majority of general medical practitioners in the county. Immunisation with this triple vaccine should commence between the ages of two and six months and a reinforcing dose is necessary at about the age of 18 months.

Smallpox Vaccination

Primary smallpox vaccination should be carried out within the first few years of life, preferably during the second year. During 1965, 4,877 primary vaccinations were performed during this second year of life, 493 during the first year, 1,388 between the ages of two and five years whilst 192 children were vaccinated after the age of five (grand total 6,950).

Poliomyelitis Vaccination

Oral poliomyelitis vaccine is now used extensively throughout the county. The vaccine is usually given to children from the age of six months (three doses), and a reinforcing dose is given at the age of five years.

Recommended Schedule of Vaccination

Age	*Vaccine*	*Interval Between Vaccine*
3 months	Triple Antigen	4–6 weeks
4 months	Triple Antigen	4–6 weeks
5 months	Triple Antigen	4–6 weeks
6 months	Oral Polio	4–6 weeks
7 months	Oral Polio	4–6 weeks
8 months	Oral Polio	
15–18 months	Reinforcing Triple Antigen and Smallpox Vaccination	
School Entry	Reinforcing Diphtheria-Tetanus Injection and Fourth Oral Polio Dose	

CARE OF THE NEWBORN

Perinatal, Neonatal and Infant Mortality

For many years infant mortality (the number of deaths occurring during the first year of life for every 1,000 live births) has been used as a measure of the efficiency of our infant welfare services. Infant mortality fell dramatically during the first half of the century. The most marked fall has taken place amongst infants aged between one and twelve months, but only a relatively small improvement has occurred in mortality in the first month (the neonatal deaths).

The improvement in mortality in the one to twelve month period owes much to the work of child welfare centres and to teaching given by health visitors in the homes, as well as to improved standards of living. In the early neonatal period—the first week of life—most deaths occur through causes present during delivery or even beforehand, and for improvements here we must look towards the maternity services.

More recently it has become the practice to group deaths occurring during the first week of life with deaths occurring before or during labour (the still-births), and to refer to these as "perinatal" deaths. The perinatal death rate is thus a valuable pointer to the efficiency of our maternity services.

RATES FOR ENGLAND AND WALES

	1961	1962	1963	1964	1965
Perinatal mortality	32·0	30·8	29·3	28·2	
Stillbirths	19·1	18·1	17·2	16·3	Not
Neonatal mortality	15·3	15·1	14·3	12·0	Available
Infant mortality	21·6	21·8	21·1	19·9	

RATES FOR BERKSHIRE

	1961	1962	1963	1964	1965
Perinatal mortality	29·38	25·01	26·81	22·2	20·6
Stillbirths	17·4	12·1	16·1	12·8	12·0
Neonatal mortality	14·57	14·57	12·06	10·9	10·2
Infant mortality	19·3	20·9	18·1	16·0	13·7

PREMATURITY

According to international definition a premature infant is one which weighs $5\frac{1}{2}$ lbs (2,500 gms) or less at birth. The perinatal mortality survey confirmed the high neonatal death rate among premature babies and those born before the 38th week of pregnancy though they may weigh over $5\frac{1}{2}$ lb.

Units for infants at special risk should be available in every maternity hospital under the supervision of a consultant paediatrician, these babies should be transferred to hospital in ambulances with portable incubators and constant supervision and after-care is required when the baby is discharged to his own home.

In Berkshire we are fortunate in that special care units are established in Battle Hospital, Reading, the Maternity Unit, Old Windsor Hospital, and at Nuffield Maternity Home, Oxford. Arrangements are made for all premature babies to be transferred to hospital in ambulances with portable incubators.

In order to provide the constant supervision and follow up care of the premature baby, arrangements were made for two health visitors to receive additional training in the Special Care Unit at Battle Hospital. On completing this training in August 1964, these health visitors were able to give the necessary supervision and care to these small babies in their own homes. Before these appointments were made, there were some instances when a baby was separated from his mother for as long as 3 to 4 months. Since these arrangements took place many more premature babies have been allowed to return home earlier to the care of their own mother. Other advantages of this scheme are that babies are not exposed to the risk of infection from contact with others outside the family; feeding problems are prevented or controlled by the advice given to the mother and any disorders are brought to the notice of the doctor at an early stage. In co-operation with the general practitioner, the Consultants at the Special Care Unit are responsible for overseeing the general policy of management and supervision of the baby at home. Arrangements are made for the regular long-term follow up by the consultant paediatrician of all premature infants born in hospital and at home.

RISK REGISTER

Since 1959 an "at risk" register has been kept in the health department. This register is a list of children, who, from their antenatal, perinatal or post-natal experiences, are considered to be at special risk of developing handicaps which are not apparent at birth, for example, deafness, blindness, or cerebral palsy. The object of the "at risk" register is to ensure that these children have special supervision by the family doctor, the health visitor and the hospital consultant. In this way it is hoped that handicaps or defects which were latent or not apparent at birth will be diagnosed as early as possible, and the

children referred for appropriate treatment.

In 1965 a meeting was arranged with Dr. Murphy from the Audiology Unit at the Royal Berkshire Hospital in order to discuss and evaluate the results of the survey of babies "at risk". The survey had shown that 33·5% of all children under two years of age were on the "at risk" register and this figure led us to the conclusion that the mesh was too fine. The list of categories were then revised, and the general procedure was simplified.

At the end of 1964, 9,181 children were on the "at risk" register and at the end of 1965, 9,651.

Congenital Abnormalities

Until recently little was known concerning the causation of congenital malformations. The thalidomide incident of 1962 drew attention to the lack of information concerning different types of congenital malformations. During 1962 the Ministry of Health requested Medical Officers of Health in England and Wales to submit details concerning children born with limb abnormalities, of the kind attributed to thalidomide. Following these enquiries a scheme was devised for notification of congenital malformations to the medical officer of health with the object of enabling a central statistical record to be compiled by the General Register Office. The notification of congenital abnormalities commenced on 1st January, 1964. Such information is provided by doctors and midwives who are present at the birth and is confined to abnormalities which are observable at birth.

A central statistical record of these malformations is now maintained in the health department. Health visitors are notified of such children and it is the responsibility of the health visitor to ensure these children have special supervision by the family doctor. It is also possible by these records to ensure that these few children are followed up and that necessary care, treatment and educational facilities are provided.

Phenylketonuria

In 1960, the Ministry of Health asked medical officers of Health of local health authorities to consider undertaking, for the detection of phenylketonuria, routine screening tests of infants between 4–6 weeks of life. If this uncommon disorder of metabolism is not detected until later life brain damage and mental defect may follow.

As one of the functions of the health visitor is to visit mothers with young children, arrangements are made for all health visitors to carry out two routine urine tests. The first test is done when the baby is between 14 and 21 days old, and the second test when the baby is 5 weeks old. One confirmed case of phenylketonuria was discovered by this routine test and promptly referred for treatment: this child is now normal and active.

CARE OF MOTHERS AND YOUNG CHILDREN

Antenatal Care and Mothercraft Classes

The W.H.O. Expert Committee on Maternity Care defined maternity care as follows:

"The object of maternity care is to ensure that every expectant mother maintains good health, learns the art of child care, has a normal delivery, and bears healthy children. Maternity care in the narrower sense consists in the care of the pregnant woman, her safe delivery, her postnatal examination, the care of her newly born infant, and the maintenance of lactation. In the *wider*

sense, it begins much earlier in measures aimed to promote the health and well-being of the young people who are potential parents, and to help them to develop the right approach to family life and to the place of the family in the community. It should also include guidance in parentcraft and in problems associated with infertility and family planning."

Mothercraft and Relaxation Classes

The respective role of mother and father, parent/child relationships and the place of the family within the community are discussed with girls whilst still at school (see page 36).

Mothercraft and relaxation classes are arranged throughout the County so that every expectant mother can avail herself of these classes.

In order to achieve the aims as defined by W.H.O., midwives and health visitors both attend these classes, each having a contribution to make. In some areas the general practitioners also attend.

By meeting in groups the mothers' feeling of isolation can be broken down. The midwives and health visitors are aware of the physical and psychological changes which occur during pregnancy and by their teaching it is possible to diminish the tensions and anxieties which may be created by ignorance and fear. Many expectant mothers are often too shy to mention these points and thus receive great benefit from group discussions. Attention is now paid to the care of the mother who returns to her own home soon after her confinement. The importance of rest and the effect of premature return to household duties are discussed with mothers during these classes.

In order to achieve greater continuity throughout the antenatal stages, two schemes were started in 1964 whereby the mothercraft classes are held at the general practitioner maternity unit and the domiciliary midwives and health visitors attend. The mothers appreciate the opportunity of meeting the staff in the maternity unit, yet keeping in touch with their own midwife and health visitor.

During 1965 it has been possible to widen this health education in the antenatal period to include fathers and fathers-to-be. In all areas an evening meeting is arranged at the end of the series so that both parents can attend. It is usual for 80–100 parents to be present, at this meeting, at which a film is shown. At some meetings the district medical officers of health and general practitioners also attend and join in the discussion.

In a few areas classes are held so that fathers and mothers can attend together. In one area arrangements were made for fathers to attend their own class. The request came from the fathers, and the midwife takes five discussion groups with each set of fathers. It is hoped to extend this idea to other areas in the county.

	1961	*1962*	*1963*	*1964*	*1965*
Number of centres	20	29	35	48	45
Number of mothers who attended	861	1,259	1,524	1,582	2,109
Total attendances	3,798	6,641	7,164	7,892	8,341

The drop from 48 to 45 as shown in the above table is due to the closure of three small centres in the Faringdon Rural District. Arrangements were made for mothers to attend the main clinic at the Faringdon Health Centre. *Good antenatal care* is of vital importance; inadequate antenatal care and lack of co-operation between general practitioners and midwives are considered to rate high among the avoidable factors causing maternal deaths.

In order to achieve this co-operation, there are no separate local authority

antenatal clinics in Berkshire. The domiciliary midwife works in partnership with the doctor throughout pregnancy, labour at home, and lying-in following this or early discharge from hospital. Whenever the doctor holds an antenatal clinic at his surgery, the attached midwife assists and many of the "unattached" staff also manage this. In 1965 there were 42 doctors' antenatal clinics, 1,453 mothers were seen and the number of attendances were 16,784. All expectant mothers, whether booked for confinement at home, in a general practitioner unit, or in a consultant unit are thus able to attend the doctors' antenatal clinic and meet the doctor and midwife. This ensures that adequate provision is made for the mother who may return home within 48 hours of her confinement in hospital.

This continuity of care is much appreciated by the mothers, who feel great confidence in the team of doctor and midwife. Such co-operation between doctor and midwife also means that antenatal care is planned, thus avoiding any overlap.

Selection and Place of Confinement

The first report of the British Perinatal Mortality Survey was published in 1963. This enquiry covered the whole of England, Wales and Scotland, and reviewed about 17,000 births which took place in the week 3rd to 9th March, 1958, together with some 7,000 stillbirths and first-week deaths which occurred during the three months, March, April and May, 1958.

The main features of this first report may be summarised as follows:

1. *Geography*

In general, the perinatal mortality rate was lowest in the southern and eastern parts of the country, and increased steadily across country northwards and westwards. Berkshire was in a region having one of the lowest mortalities (86% of average).

2. *Parity of mother*

Perinatal mortality rates were lowest where the mother was having her second baby, average for first and third babies, and then progressively increasing in successive pregnancies.

3. *Social Class*

There was a pronounced mortality gradient, lowest in Social Class I (wives of professional men, business executives, etc.) and highest in Social Class V (wives of unskilled labourers). This gradient is also typical of many other conditions.

4. *Age*

The perinatal mortality was below average where the mother was between 20 and 30, slightly above average for teenage mothers and those between 30 and 35, but beyond this there was a progressive increase with age.

5. *Obstetric History*

Where there had previously been a miscarriage, a premature birth, a stillbirth or neonatal death there was a much increased risk of perinatal death.

6. *Place of Delivery*

Delivery under the care of the general practitioner in the patient's own home or in a maternity unit can be very safe—indeed, the mortality in this group of patients who were properly selected was only half the average. Unfortunately, the extreme high mortality for patients transferred from home or

maternity unit to a consultant hospital in confinement (many of whom should have been booked for consultant hospital originally) was over three times the average and brought the overall mortality up to about 88% of average. Those booked for and confined in hospital showed a mortality of only 103% despite the fact that this group will have included many where difficulties were expected and met. Together these figures emphasise the vital importance of correct selection and booking of patients for confinement.

In the report facts were presented which showed that the selection of mothers for care in consultant obstetric units in 1958 was far from satisfactory. Only 40·9% of the population were booked for and delivered in consultant hospital units. Hospital deliveries were finally achieved by 49·1% of mothers, while 12·1% were delivered in general practitioners units and 36·1% at home.

The following table shows the actual place of confinement for all births in Berkshire during 1964 and 1965:—

	1964		*1965*	
	Number of Births	*Percentage*	*Number of Births*	*Percentage*
Consultant Hospital Unit	3,985	44·1	4,370	46·6
General Practitioner Unit	2,618	29·0	2,640	28·1
Home	2,434	26·9	2,383	25·3
	9,037	100%	9,393	100%

After considering the report of the Perinatal Mortality Survey, the Reading and District Local Maternity Liaison Committee and the Windsor Group Maternity Liaison Committee decided to seek further information about "High Risk" mothers who should have been cared for in consultant obstetric units, but who were for one reason or another booked for (a) G.P. units or (b) home delivery.

In order to obtain the latter information, a survey of Berkshire mothers booked for home confinement and delivered during the four-month period 1st September–31st December, 1964, was carried out. The results of this local survey reflected some of the main findings of the Perinatal Mortality Survey.

In 1965 a similar survey was carried out for the corresponding period 1st September–31st December, 1965.

The following table analyses some of the factors which it may be felt should have influenced the original booking or later led to a revised booking. The table shows the comparisons for the 4-month period 1964 and the 4-month period 1965.

ANALYSES OF CASES BOOKED FOR HOME CONFINEMENT DURING THE FOUR MONTH PERIOD 1st SEPT.–31st DEC., 1964 and 1st SEPT.–31st DEC., 1965

	1964			1965		
	Booked and delivered at home	*Booked at home, delivered in hospital*	TOTAL	*Booked and delivered at home*	*Booked at home, delivered in hospital*	TOTAL
TOTAL DELIVERIES	701	168	869	679	128	807
Primipara under 18 years	2	—	2	1	—	1
Primipara 30 years or over	2	2	4	1	—	1
Grand multip: para 4 or more	36	13	49	19	6	25
Medical history	(22) 18	(7) 4	(29) 22	5	—	5
Obstetric history	(82) 61	(41) 33	(123) 94	4	—	4
Rh. neg. (para 2 or more)	(44) 26	(5) 7	(49) 33	(44) 42	(7) 8	(51) 50
SUB TOTAL: total at risk at time of booking	145	59	204	72	14	86
Late anaemia of pregnancy under 75%	(96) 75	(26) 17	(122) 92	(95) 94	(20) 13	(115) 107
Toxaemia	(48) 33	(49) 34	(97) 67	(11) 17	(29) 28	(47) 45
Breech unsuspected	2	2	4	—	—	—
Breech known	2	(14) 6	(14) 8	—	(9) 8	(9) 8
Multiple births	1	(2) 1	(4) 2	2	3	5
Premature births	(18) 11	(12) 2	(30) 13	(9) 7	(12) 6	(21) 13
SUB TOTAL: total at risk subsequently	124	62	196	120	58	178
TOTAL AT RISK	269	111	390	192	72	264

N.B.— Figures in brackets show the totals for each category where secondary factors are involved.

It is worthy to note certain factors which have become apparent in the 1965 survey.

(i) There has been a marked improvement in haemoglobin estimations

	1964	*1965*
2 haemoglobin tests	24%	50%
only one haemoglobin test	66%	48%
no haemoglobin test	10%	2%
	100%	100%

(ii) Primipara 30 years or over:

Only one elderly primipara was booked for home confinement in 1965 as against 4 in 1964.

(iii) Grand Multipara:

The total number of grand multipara fell from 49 in 1964 to 25 in 1965. Out of this 25, 24 were para 4 and one para 6.

(iv) Medical History:

A marked improvement has been shown. The five cases mentioned as delivered at home were for hypertension (Blood Pressure 140/90) at time of booking, but there was no increase in blood pressure, nor any other signs of toxaemia.

(v) Obstetric History:

Again a very marked improvement; 4 cases only as against 94 the previous year.

(vi) Rhesus Negative and Para 2 or more:

Although this shows an increase during 1965, in all cases a careful watch was kept on the blood results and every mother who was reported to have antibodies was immediately admitted to hospital.

(vii) Late anaemia of pregnancy:

This number also shows an increase over 1964, but must be related to the improved standard of haemoglobin estimation.

(viii) Premature births:

The 21 premature babies born at home all weighed between 5 and 5½ lbs, and showed no signs of immaturity.

(ix) Multiple Risk Categories:

In 1964 a disturbing number of mothers booked for home delivery fell into more than 1 risk category. The following figures illustrate a welcome improvement in 1965:—

	1964	*1965*
More than one risk factor at time of booking	55	3
More than one risk factor at time of delivery	136	24

(x) Perinatal Deaths:

In 1964 there was a total of 13 perinatal deaths, 3 following home confinements and 10 in babies born in hospital following transfer of the mother. During 1965 there were only 3 perinatal deaths, 1 following home confinement and 2 where the mother was booked for home confinement but delivered in hospital.

These two surveys carried out in Berkshire meant extra work for the domiciliary midwives, who undertook this task willingly, hoping it would lead to an improved pattern of maternity care and more careful selection of mothers for care in consultant obstetric units. It is thus gratifying to see the improved results following the first survey of 1964.

Birth Rates

The following table illustrates the growth in the birth rate and the changing pattern of place of confinement since 1958:—

Year	*Number of Live Births*	*Birth Rate per 1,000 Population*	*Percentage of Hospital Births (including G.P. Units)*	*Percentage of Home Births*
1958	6,767	19·02	67·6	32·3
1959	7,060	19·29	66·3	33·6
1960	7,608	20·18	67·2	32·8
1961	7,893	20·11	67·6	32·4
1962	8,330	20·52	67·9	31·1
1963	8,624	20·66	69·7	30·3
1964	8,921	20·6	73·1	26·9
1965	9,280	20·7	74·7	25·3

Maternal Mortality

In the past ten years the maternal mortality rate for England and Wales has been reduced by approximately half. Whenever a maternal death occurs a searching examination is made into the medical history of the case, and confidential reports are submitted and analysed nationally.

In 1964 there was one maternal death in Berkshire and two such deaths occurred in 1965. Details of these deaths are as follows:—

Year	*Age*	*Causes of Death*	*Place of Death*
1964	22	Toxaemia and post partum uterine infection	Hospital
1965	26	Pulmonary embolus	Hospital
	27	Cardiac failure and cardiomyopathy	Hospital

Hospital Confinement and Early Discharge

With improved selection for confinement, a changed pattern of midwifery is now evolving. It is apparent that the pressure of public demand is towards confinement elsewhere than in the home, yet very few mothers choose to spend the full lying-in period in hospital. With careful selection for confinement and the admission of all "high risk" cases to a consultant unit the length of stay in hospital is reduced in order to increase the turnover of cases, and so the availability of beds. Midwives in Berkshire accept this new pattern of work but all have stated that they prefer the mother to be discharged within 48 hours of confinement rather than between the 3rd and 7th day. We feel that the discharge of patients between 48 hours after birth up to the eighth day is much less desirable.

The mother discharged on the seventh or eighth day after delivery does not necessarily require attention from a midwife. In such cases arrangements are made for the health visitor to visit the day of discharge in order to provide a better sense of continuity to the mother, and to help her past the early anxieties of baby management.

If early discharges can be planned it is then possible to assure that adequate help is available on the mother's return home. The mother discharged early from hospital is clearly entitled to the same help and support as a mother confined at home.

It is the responsibility of the midwife to consult with the health visitor and to see that adequate help is available. In most instances relatives are prepared

to do this. Little use is made of the Council's home help service, in maternity cases, as many families are not willing to pay the full cost.

The number of early hospital discharges have increased rapidly over the past five years, as indicated.

	1961	*1962*	*1963*	*1964*	*1965*
Number of early hospital discharges	1,281	1,363	1,954	3,005	3,546

During 1965 it has been possible to ascertain the time after delivery when these discharges took place.

Within 48 hours of delivery	23% of all early discharges
Between 2 and 6 days	39% " " " "
Between 7 and 9 days	38% " " " "
	100%

Home Confinement and Post Partum Care

It is true to say that some mothers prefer to be confined in their own home and if there is a low risk such a choice has the advantage that the doctor and midwife in whom the mother has confidence will be responsible personally for her antenatal care, her delivery, and the care for 10 days after delivery. This continuity of care is one reason why midwives choose to work on the district rather than in hospital. Pupil midwives who train in Berkshire also enjoy the more personal contact with the mother and her family. Many mention that their time on the district is the first opportunity they have had of being able to see the mother in the antenatal period, to attend her at the confinement and to continue care of the mother and her baby during the puerperium.

During 1965, 38 pupil midwives undertook their district training in the County. Arrangements were also made for 25 obstetric nurse students to spend 1 day with the domiciliary midwives.

All midwives are supplied with modern equipment and all will have been issued with gas and oxygen machines for analgesia by March, 1966.

It is part of the midwife's duty to visit for 10 days following a home confinement. The first week or two following the delivery is a time of physical adjustment for both mother and baby and a time when psychological adjustments have to be made. In the case of the first baby, the mother must learn how to handle him and gain confidence in her ability to do so. It is the midwife's responsibility to help the mother so that she can assume her motherhood with complete self-confidence.

As these early days are a time when the baby is particularly susceptible to infection and chilling, midwives pay particular attention to maintaining the room at a steady temperature. All midwives are issued with special low reading thermometers so that the babies temperature is taken daily and when there is any sign of chilling, medical advice is sought.

The Unmarried Mother

Approximately one in every twenty births are illegitimate and there appears to have been a slight upward trend in this proportion over the past five years. This is illustrated by the following tables.

	Percentage of Illegitimate Births	
	National	*Berkshire*
1961 ..	5·9	4·61
1962 ..	6·6	5·07
1963 ..	6·9	5·51
1964 ..	7·2	5·1
1965 ..	not available	5·5

Emotional maladjustment or poor inter-personal relationships are often present in unmarried girls who become pregnant. Even if these emotional stresses are not present beforehand, they will almost certainly develop because of the pregnancy. To help unmarried girls with these problems involves skilled case work over a prolonged period, and the County Council has an agency arrangement with the Oxford Diocesan Moral Welfare Association who supply two full time and five part-time moral welfare workers in Berkshire.

During 1964 and 1965 63·2% of unmarried mothers in Berkshire were visited by moral welfare workers.

In a considerable number of cases satisfactory arrangements can be made for the mother without the need for admission to mother and baby homes. During 1964 17% were admitted to a mother and baby home and 11·6% in 1965.

The provision of residential care for pregnant single women and unmarried mothers is of vital importance. Such residential care is provided for 19 expectant or nursing mothers with their babies, at the County Council's own hostel, Burnell House, Windsor.

The present home is set in pleasant grounds, but the house itself requires certain adaptations in order to make the building more homely and to bring it up to modern standards. During 1965 it was agreed that the adaptation and improvements required, together with some refurnishing should be carried out.

In December 1964 the warden retired through ill-health, and it was decided to alter the administration and staff establishment. The County Nursing Officer was asked to undertake a supervisory role at the Hostel and the staff establishment amended to a Sister-in-Charge and a sister, and housekeeper. The Sister-in-Charge and the housekeeper were appointed in December 1964 and the sister in February, 1965.

During 1965 it has been possible to organise more activities for the mothers on the understanding that such activities are voluntary and that the mothers are free to attend or not. A weekly club is now held when points of interest are discussed and health education undertaken. The mothers themselves choose the subjects with the sister-in-charge. During the year the following topics have been discussed:

(i) The art of grooming and the use of make-up.
(ii) Venereal disease and social services available.
(iii) Care of a young baby.
(iv) What is meant by "adoption".
(v) The services available to help a single girl who wishes to keep her own baby.
(vi) Home safety and prevention of accidents.
(vii) Smoking, the effects and dangers.
(viii) Films on various aspects of health education, followed by discussions.

Weekly classes are also held for mothercraft and relaxation so that the services available to all expectant mothers in the County are also available for the unmarried mother.

More leisure activities have also been arranged, games, table tennis, cookery practice, and instruction, and practice in needlework. It is gratifying

to see how successful these classes and activities have been and that a more homely atmosphere now exists.

The number admitted during 1964 was 92 (82 antenatal, 10 postnatal) including 22 from other local authorities' areas. During 1965, 93 were admitted (78 antenatal, 15 postnatal) including 39 from other local authorities' areas.

In order to achieve full co-operation between the local authority staff and moral welfare workers a meeting was held at Burnell House in November, 1965. The meeting was attended by all the moral welfare workers who admit cases to Burnell House, the sister-in-charge, the clerk responsible for the administrative arrangements and the county nursing officer. Following this meeting it has been possible to arrange more continuity in the antenatal care and improved arrangements for blood tests.

Such meetings will be held each year so as to prevent fragmentation of the services provided and a lack of a cohesive policy.

Child Welfare Centres

In May 1965, at the request of the Health Committee, I reported on the functions of the child welfare centres and the future trends which should be considered in the light of changing medical needs and the changing role of the family doctor.

The *present* position in Berkshire is that there are 100 centres; 41 meet once a month, 34 fortnightly, and 25 hold weekly or twice weekly sessions. Only two centres are held in premises designed for this purpose; the vast majority are held in village or church halls, community centres, and similar premises offering widely varying standards of accommodation.

The facilities provided in these centres include the following (not in order of importance):—

(i) weighing of babies;
(ii) social contact with other mothers of young children;
(iii) advice from health visitor;
(iv) routine medical checks;
(v) immunisation and vaccination;
(vi) sale of welfare foods.

In considering the place of the child welfare centre in *future* one must bear in mind two important factors; (i) the changing pattern of infant mortality and morbidity resulting from the success of our earlier efforts, and (ii) the changing pattern of medical care in a still evolving National Health Service.

Now that 49 out of every 50 infants survive and are so healthy physically, our attention is turning more and more to perfect *function*—do they hear and see perfectly, are they developing speech and other skills at around the usual stages, are they happy, what sort of relationships do they make with other children, and—in due course, are they breaking away from mothers' apron strings?

The activities within child welfare centres have not changed in essence since they were started by voluntary effort 60 years ago. In 1948, the National Health Service made available a *family* doctor, someone interested in all members of the family, both in sickness and in health.

It was suggested that:—

(i) The routine weighing of healthy babies has little to commend it except on special instruction of doctor or health visitor.
(ii) Parents clubs might provide better opportunities for both social and health education than do child welfare centres.

(iii) The family doctor will assume an even bigger role in the future; both he and the "clinic" doctors will devote attention more to function and emotional development than merely to physical examination.
(iv) Immunisation and vaccination should be available at all centres.
(v) That toddlers playgroups should be arranged in areas where parents' clubs exist and meet in the afternoon, both for the value of the play and as a means of observing their development.
(vi) National policy on welfare foods should be reviewed.

The Health Committee gave more detailed consideration to this at a subsequent meeting. It was felt that with the low uptake of "government" welfare foods and with adequate supplies of proprietary foods available there should be no need, 20 years after the end of the second world war, for local authorities to be obliged to continue their distribution. The County Councils Association has adopted a suggestion from the Council that the Ministry of Health be asked to review their policy. Secondly, the Health Committee were concerned over the wide range of products on sale at some centres, many items being of no conceivable benefit to the *health* of young babies. Members were mindful of difficulties of parents in some rural areas, however, and felt that as a compromise, sales of a restricted range of foods should continue. To give local voluntary helpers full discretion, each centre has free choice up to a maximum of two proprietary milk powders, two weaning foods, a Vitamin C and a Vitamin A and D preparation in addition to "government" foods.

Following this report a meeting was held so that voluntary workers could be informed of the Councils' decision and future trends.

Toddlers Sessions

Family doctors are taking an increasing interest in young children and some hold special sessions in their surgeries by appointment for routine checks. This is, of course, an ideal arrangement, especially where the health visitor is attached to the doctors' group practice.

Separate toddlers' sessions are now arranged in four of the existing child welfare centres. Playgroups are organised for the toddlers, and discussion groups on toddler development are held with the mothers. The doctor and health visitor attending the clinic plan the programme and it is thus possible for one to observe the toddlers at play while the other joins in the discussion group. With this changing pattern it has become possible to concentrate less on individual physical examination in the clinic and for more time to be spent on functional tests (e.g. hearing, speech, behaviour, etc.), by observing groups of toddlers at play.

In three areas, a toddlers' play group has been organised where a parents' club was already in existence. In all three areas, it has been possible to arrange for the attendance of a doctor at least once monthly.

Although these sessions were only started in 1965, it is already apparent that they are proving most worthwhile and that parents are learning that every child is different.

It is hoped to develop further toddlers sessions in 1966.

COMMUNITY NURSING SERVICES

The Community nursing service includes the three branches of health visiting, midwifery and home nursing. In Berkshire all three services are under the general direction of the County Nursing Officer, and likewise the Area Nursing Officers have an interest in all three branches in their areas.

Throughout 1964 and 1965 the full establishment of staff were employed. In Berkshire, where there is a rapid increase in population and in consequence a steady increase in the number of staff employed, there is an ever increasing need to ensure that good communication exists with all members of staff. This basic principle is essential in order to maintain a contented and efficient service. To achieve this, area staff meetings are held at regular intervals, so that the county nursing officer is able to meet each individual member of staff at least five times a year. Nurses, midwives and health visitors attend these meetings so that they are able to interchange their ideas. Such meetings afford an opportunity to discuss policy and to orientate staff to accept changing attitudes and future developments.

Consideration has also been given to ways in which it is possible to improve liaison and links with hospital staff, social workers, and voluntary agencies. At the Royal Berkshire Hospital, Reading, and King Edward VII Hospital at Windsor it was possible to arrange an afternoon at each hospital so that medical social workers, ward sisters, health visitors and district nurses could meet. A discussion took place on the work of the domiciliary nursing staff and the care that could be given to patients in their own home. Both these meetings were so successful that it is hoped to arrange such meetings yearly in order to continue this greater understanding between hospital and local authority staff. During 1965 four staff meetings were used in order to meet and learn of the work of other social workers and voluntary workers. Mental Welfare Officers, teachers of the Blind, teachers of the Deaf and Moral Welfare Workers were able to attend a staff meeting. This opportunity of personal contact and discussion has given us greater understanding of each other's responsibilities and has helped to emphasise the importance of liaison between all workers who visit people in their own homes.

Attachment of Nurses, Midwives and Health Visitors to Group Practices

In the Annual Report for 1963 mention was made that plans were being considered for closer association of the domiciliary nursing staff with the general practitioners. During 1964 experimental schemes were started with 17 group practices consisting of 57 doctors. It was planned that nurses, midwives and health visitors should be attached to each group practice so as to maintain the full co-ordination of these services and the integration of the preventive and curative aspects of nursing.

The County Nursing Officer and I visited all 17 group practices after the scheme had been in operation for at least 6 months.

It was interesting to find that some doctors invited the domiciliary nursing staff to the meeting as they considered that they were an integral part of the group practice. We also had separate meetings with staff. All were unanimous in their comments on the value of the system, and views may be summarised as follows.

(a) *General*

(i) Ease in communication had vastly improved. Regular personal contact led to greater co-operation between doctor and staff, and for the better understanding of the patients' illness and social background.

(ii) There had been a notable increase in morale of all concerned. The domiciliary staff now felt a part of the practice team.

(iii) More use was made of all services, and there had also been an overall increase of work for the doctors, combining to provide better patient care.

(b) *Nursing*

(i) Patients with more acute illness could be nursed at home. Patients who previously would have been admitted to hospital were now being kept at home and some were being discharged even earlier from hospital, as the doctors felt more confident with a domiciliary team!

(ii) In some cases nurses' time has been saved, as ambulant patients attend at special times in the surgery, rather than receiving a home visit.

(iii) Personal discussion of the patients' progress between doctor and nurse enabled nursing visits to be discontinued at the right moment (but earlier than under the old system) thus contributing to quicker patient turnover.

(c) *Midwifery*

(i) All doctors mentioned that they had had a good link with the midwives before, but the attachment had led to even closer working.

(ii) As the midwife was now working for only one practice, she could attend the doctor's antenatal clinic.

(iii) Antenatal care could now be planned between the doctor and midwife, thus avoiding overlap.

(iv) The continuity of care was much appreciated by the mothers, who felt greater confidence in the team of doctor and midwife.

(d) *Health Visiting*

The work of the Health Visitor was not so well known to the family doctor. All doctors expressed their surprise at the help they had received from the health visitors; several commented "previously we had no idea what a health visitor could really do".

(i) Problems in families which were unknown to the doctors were now brought to their notice.

(ii) Many more social problems were now referred by the doctor to the health visitor for attention.

(iii) The health visitor had been able to relieve the doctors of some work, especially with the care of the elderly. The health visitors are now increasingly aware of the elderly who require help and support.

(iv) With improved communication the health visitor was able to visit a family instantly when an urgent social problem occurred.

(v) The health visitor had opened the door to other agencies which could help the general practitioner in the care of such groups as the elderly, the mentally ill, and the physically handicapped.

(vi) That there was continuity of care and advice to the young mother and her family, and no longer risk of conflict of advice.

(vii) The doctors now have a greater appreciation of the health visitors role as a health educator. Some doctors were already sharing in the discussion groups held in the pre-natal period and others expressed a desire to participate in health teaching activities.

We were aware of certain theoretical disadvantages and possible difficulties that could arise, and great care was taken to avoid these when planning an attached service.

The arguments which have been adduced against the system include:—

(a) "Why should the staff be 'given away' to doctors, and the local authority lose control?"

This is, of course, a misconception. The function of the local authority is to provide an efficient service, to ensure proper location of staff and to maintain high professional standards. None of these functions is lost with attachments. Indeed, they are carried out more effectively where attachments exist. The relationship between these general practitioners and the staff of the local authority is now even friendlier and the general practitioners are more aware of other services provided by the local authority.

(b) "The doctors will misuse staff."

This could presumably happen. We have felt it vital to discuss proper use of staff before commencing attachments, and to keep a close eye on the scheme in its early stages.

In the attached areas we have found that the staff have been employed more wisely as the doctors are now aware of their potentials, skills and special aptitudes. Incidentally, the doctors' time and skills are also being employed more effectively.

(c) Personalities.

This is a difficulty which may arise from time to time whether staff are attached or not, but great care is taken in placing staff with each group practice. No real difficulty has been experienced so far.

(d) Difficulties of relief when "attached" staff are on holiday or away sick.

The relief arrangements have in fact been easier since the group attachments were started, and have obviated a frequent cause of complaint. The doctors have a complete off duty rota for the staff working with them. All doctors understand that in emergency their staff may have to help in other practices.

(e) "Extra travelling is involved when staff are no longer confined to a compact area."

A survey was made of staff travelling in two attached areas and in two control areas. The results failed to show any difference between the attached and control areas.

(f) "A family may have more than one doctor."

In the few instances in which this has occurred, one member of staff deals with both patients and passes on any relevant information to the nurse, midwife, or health visitor who might be visiting for another practice, thus avoiding this duplication. We find that doctors strongly discourage, or even refuse, to accept individual patients from families on another practice list.

(g) The role of the health visitor as "parish priest" of health is lost.

The health visitor, although she must collaborate with the family doctor, has certain professional responsibilities of her own. She should be the "parish priest" on health matters in her area—it has been argued—this role becomes lost when practice lists are substituted for geographical areas.

Health visitors involved in the experiment do not feel that the danger is great, and say that if they spot a health problem they will investigate first and, if another practice is involved, pass the information to the appropriate colleague for action. Our own impression is that "attached" health visitors will be more, rather than less aware of families needing her help than her "unattached" colleagues.

(h) Doctors' practice areas straddle local health authority boundaries.

If attachments are to be fully operative everywhere without

artificial geographical barriers, staff will eventually have to nurse some patients resident in another local authority area. Discussions with colleagues in neighbouring areas lead us to believe that administrative difficulties are minor and can readily be overcome.

In view of the overwhelming advantages of the system and the lack of evidence of any disadvantages, the County Council agreed that the scheme should be gradually extended to other areas where general practitioners so requested. At the end of 1964 a total of 70 domiciliary nursing staff were attached to doctors group practices (18·5 health visitors, 7 nurse/midwife/health visitors, 17·5 midwives, and 27 nurses). By the end of 1965 the scheme had extended so that 40 group practices consisting of 107 doctors had attached to them a total of 146·5 domiciliary staff (42·5 health visitors, 16·5 nurse/midwife/health visitors, 25·5 midwives, 52 nurses and 10 nurse/midwives).

It is hoped to extend the scheme yet further in 1966, and to experiment with "cross boundary" arrangements which were agreed in principle by the Council late in 1965.

Work Study

In June, 1965, following receipt of Ministry of Health Circular 12/65 on "Use of ancillary help in the local authority nursing service" it was decided to undertake a study of the work done by the nursing staff, to ascertain the time spent on the various activities, and to analyse the results according to the kind of district, and the type of post.

Following a pilot study in July, all members of the domiciliary nursing service were asked to participate in a work study during the month of August. As August is a holiday month the study was repeated in November, 1965, and in order to ensure that we have a truly accurate picture throughout the year, it is planned to do further studies in February and May, 1966. The study was so planned that the results would show a cross section of the week, Monday to Friday, as well as work undertaken at the weekends.

The results of the August work study were most useful to the Health Committee when considering the revision of the 10 year plans. Some findings are summarised below:—

Health Visitors

Work study undertaken by fifty full time and six part time health visitors.

(i)	Average daily hours on duty	8·6
(ii)	Percentages of time on varying duties:	
	Visiting families	41
	Fixed sessions	18
	Travelling	24
	Record keeping	14
	Preparing visual aids	1
	Telephone calls	2
		100%
(iii)	Details of Family Visiting:	
	Parents and children under five years of age	21·5%
	Schoolchildren	1·0%
	The elderly	8·0%
	The mentally disordered	2·0%
	The physically handicapped	1·0%
	Hospital after care cases	1·5%
	Other groups	6·0%
		41%

(iv) Details of Fixed Sessions:

Child Welfare Clinics	11·0%	18%
Mothercraft and Relaxation classes	3·0%	
Mothers' clubs	1·0%	
Immunisation clinics	2·0%	
Case conferences	1·0%	

(v) Record keeping:

Professional records which can only be done by a health visitor	8·0%	14%
Records which could be done by a Clerk/typist	6·0%	

HOME NURSES

Work study undertaken by seventy-three full-time and twenty-one part-time nurses.

(i) Average hours on duty per day:

Monday–Friday	9	8
Week-ends	5·6	

(ii) Average visits per working day:

Monday–Friday	12·5	10·9
Week-ends	7	

(iii) Percentage of time on varying duties:

Nursing care	67
Visiting doctors for consultation	2
Travelling	22
Record keeping	6
Caring for equipment	2
Telephone calls	1
	100%

(iv) Details of Nursing Treatment given:

Nature of Treatment	*Percentage of all treatments*
General nursing care	25
Baths in bed	9
Baths in bathroom	4
Baths in chair	4
Enemas, douches, and other minor treatments	16
Pedicure only	1
Surgical dressings	10
Injections only	21
Injections with other nursing care	4
Advice only	2
Rehabilitation	4
	100%

(v) Type of nurse by whom treatment could be given:

Grade of Nurse	*Percentage of Treatment*	
	Weekdays	*Week-ends*
S.R.N.	49	56
S.E.N.	40	36
Auxiliary	11	8
	100%	100%

Midwives

Work study undertaken by thirty full-time midwives.

(i) Average hours on duty per day:			
Monday–Friday	8·5	7·9	
Week-ends	6·5		
(ii) Percentage of time on varying duties:			
Maternity duties, pre-natal, and postnatal	60		
Fixed sessions	12		
Travelling	18		
Record keeping	5		
Caring for equipment	3·5		
Telephone calls	1·5		
	100%		
(iii) Details of Maternity Duties:			
Visiting mothers in labour	19	60%	
Nursing mothers who are confined at home	15		
Care to mothers discharged from hospital	9		
Antenatal visits	13		
Visiting doctors for consultation	1		
Other visits	3		
(iv) Details of Fixed Sessions:			
Doctors antenatal clinics	9	12%	
Mothercraft and Relaxation classes	3		
(v) Details of Early Hospital Discharges			
Time of Discharge	*Percentage*		
Within 48 hours	31·5		
Between 48 hours and 6 days	37		
On 7th day or subsequently	31·5		
	100%		

Staff Who Combine Duties in Two or More Services

The Work Study was also undertaken by forty-two nurse/midwife/health visitors and seventeen nurse/midwives. The results showed a broadly similar pattern, but the analysis of the division of duties is of interest.

Nurse/Midwife/Health Visitor

(i) Average hours on duty per day:		
Monday–Friday	$8\frac{3}{4}$	8·1
Week-ends	$6\frac{1}{2}$	
(ii) Percentage of time on varying duties:		
Health visiting	31	
Home nursing	17	
Midwifery	20	
Travelling, records etc.	32	
	100%	

Nurse/Midwives.

(iii) Average hours on duty per day:		
Monday–Friday	8	7·4
Week-ends	6	
(iv) Percentages of time on varying duties:		
Home nursing	31	
Midwifery	38	
Travelling, records, etc.	31	
	100%	

Comments on Results of Work Study

(i) Health visitors have the longest average working day. The pattern of the work revealed is satisfactory, especially the high proportion of time spent visiting, although the time devoted to older members of the community should be increased.

It is interesting to compare the results of work study undertaken in Berkshire with the figures given in the Report of the Sub-Committee on the use of Ancillary Help in the Local Authority Nursing Services. The figures given in the report of the Sub-Committee were based on three recent studies, although no mention is made as to the type of area.

	Percentage of Working Hours	
	Areas quoted by	
Duties	*Sub-Committee*	*Berkshire*
Visiting	30	41
Attendance at clinic ..	30	18
Other duties	8	3
Travelling	12	24
Clerical work	20	14
	100%	100%

In Berkshire the health visitor has been kept reasonably free from duties not requiring her skills, although 6% of time is spent on clerical duties which could be undertaken by a clerk/typist.

(ii) The August study showed that nurses were somewhat overworked on weekdays, but underworked when on duty at week-ends. The off duty was modified to correct this unbalance, and a more even pattern was shown in the November study. Approximately half their work could be undertaken by someone less highly trained. The Health Committee decided that no further S.R.N.'s should be appointed and all additional appointments should be either S.E.N. or auxiliaries. This is expected to result in a saving, on present day salary scales, of some £25,000 per annum by 1976.

(iii) The August study showed that the work of the midwife was also slightly unbalanced as between week-day and week-end. This was similarly rectified by modification to off duty arrangements.

(iv) Staff working as Nurse/Midwife/Health Visitors are spending the highest proportion of time on health visiting duties. This result is not surprising as care has been taken to arrange that part-time nurses should help the triple qualified nurse so as to ensure she has time to attend to her work as a health visitor in the community.

(v) Some clerical help should be provided for health visitors as and when suitable clinics or other bases become available.

(vi) Pre-sterilised equipment should be provided for nurses and midwives whenever practicable.

CARE OF THE ELDERLY

The basic need of all old people is for a home of their own where they can enjoy privacy and comfort. Other basic needs include occupation, affection and the need to be needed. The majority of old people are able to live in their own homes, alone or with others, some in complete independence and others needing the supportive help of health and welfare services.

Our aim is therefore to allow old people to stay in their own home as long as it is possible, and to help them keep fit at home. Unfortunately, there are some who become too infirm to live at home, even with the help of the supportive services, and this minority group will require residential accommodation either in homes provided through the Welfare Services Committee or in hospital.

A. Provision of Services to Keep Old People fit at Home

1. *Housing*

In order to assist district councils in providing accommodation with welfare facilities arrangements are made by the Welfare Services Committee so that financial help can be given under certain conditions. Many district councils have made great efforts to provide such accommodation and much credit is due to these councils. It is usual for such accommodation to consist of one or more of the following arrangements:—

(i) Specially designed flats or bungalows that can be easily run by an old person. Such accommodation is provided by the district council without a warden.

(ii) Group bungalows for the elderly with one bungalow provided for a warden. A scheme of communication is then provided between each bungalow and the warden's bungalow.

(iii) Large block of flatlets with a warden on call within the block—a separate flat is thus provided for the warden.

2. *Health Visitors*

The role of the health visitors in this important aspect of her work is threefold:—

(i) to ascertain the old people in her area who require help;

(ii) to give advice to the old person and relatives on "maintenance of health";

(iii) to see that full use is made of existing resources.

(i) *To ascertain the old people in the area*

It is the accepted responsibility for all health visitors to be aware of any needy person or any specific need that arises and to act accordingly. Health visitors are in touch with the family in all its aspects—birth, illness, old age, health and in sickness. Now that health visitors are being attached to doctors group practices, it is possible for them to be increasingly aware of the elderly who require help and support.

(ii) *To advise on "maintenance of health"*

Old age can bring a sense of frustration to the individual and difficulties to the relatives. The health visitor is able to explain the normal physiology of old age to the individual old person and to the relatives. This understanding of the normality of old age is one step towards producing "happiness", which it is agreed, is the first promoter to health.

For health to be maintained the essential comforts must also be provided. These would include warmth, a varied and normal diet, warm and loose fitting clothes, and reasonable toilet facilities. The health visitor with her nursing background is thus in an excellent position to provide this help. All staff have been issued with low reading thermometers and regular temperature recordings are taken for elderly people at risk to hypothermia. Many old people do not bother to feed themselves adequately and health visitors pay particular attention to the dietary needs of old people. Diet sheets which have been agreed by the consultant geriatricians are available for old people or those who care for them.

With this understanding of the physiology of old age and the basic needs

of old people much help can be given to the old person and to the person caring for them. Many of the problems that arise can be foreseen and prevented. With early recognition of some symptoms, treatment can be started with good results. Where co-operation exists between the health visitor and the general practitioner a very worthwhile service is given to the elderly in their own homes.

(iii) *To make full use of existing resources*

In most areas there are voluntary societies and organisations who take an active interest in the care of the elderly. One of the greatest tragedies of old age is loneliness, and regular friendly visiting can do much to help the elderly who are housebound.

The meals on wheels service is now organised in an increasing number of areas. Credit for this service is given to the County Welfare Services Committee, the W.V.S. and other voluntary organisations. The meals on wheels service has proved an immense help in keeping the elderly fit at home.

Health visitors are aware of the help which voluntary organisations can give, and the voluntary workers now know the help the health visitor can bring to the family.

In April 1965 a full-time County Organiser of Old Peoples' Welfare was appointed by the Berkshire Old Peoples' Voluntary Committee. In many areas there is now regular consultation between the statutory and voluntary services, and it is expected that even closer links will be achieved in the future.

3. *Clubs*

There are 120 old peoples' clubs organised by voluntary associations. These clubs are well attended by the old people throughout the County. Such clubs provide an opportunity for the old to have contact with each other, they give old people an object, somewhere to go and something which they can look forward to as a regular part of their lives.

Plans are now being considered to extend the role of the clubs to include health education, maintenance of health and means of activation.

B. Treatment at Home

Nursing

This part of the home nurses' work continues to grow with the growth in the total numbers of the elderly and the increase in numbers discharged after hospital treatment.

This aspect of nursing is interesting as there are so many facets. The main responsibilities of the nurse are:—

(i) to give skilled nursing care with rehabilitation;
(ii) to teach relatives how to handle an old person;
(iii) to prepare old people for hospital, if hospital treatment is required.

1. *To give skilled nursing care with rehabilitation*

The main illnesses occurring with the aged are cerebral thrombosis, chronic rheumatic disease, bronchitis and chest conditions, and general infirmity with some confusion.

The nurse caring for the patient who has had a stroke makes him her partner, and encourages him to help himself. In consultation with the doctor exercises can be started at once, and a large proportion of these cases should improve if treated at home. Even when no apparent improvement occurs the nurse does not give up, and such treatment is continued with the expectation that improvement will eventually occur.

With the patient suffering from chronic rheumatic disease, the emphasis is again on activity, and the patient must be encouraged to be as independent

as possible. The nurse herself should think up gadgets that could be used for each specific case.

It is said that old people have to be teased, bullied or pushed back to life as well as treated.

Incontinence is usually found amongst this group of patients. A survey was carried out for five months from January 1st to 31st May, 1964, in order to ascertain the size of the problem. During this period 256 incontinent elderly patients were nursed at home. The provision of incontinent pads has eased the nursing care of these patients at home and has also eased the strain on the relatives. During 1964, 15,360 incontinent pads were issued and in 1965, 28,230.

The disposal of these pads does not produce a great difficulty, as they can usually be burnt. In one area, where difficulties existed, the District Medical Officer of Health was contacted. Arrangements have been made for special plastic bags to be issued to the nurses so that the pads or disposable equipment can be put in the bag and collected regularly by the district council.

2. *To teach relatives how to handle an old person*

The care of old people is no easy task if they are infirm. The appearance of an old person is misleading as so often their faces show nothing that is in their mind. Old people have a great fear of social dependency. Relatives need to understand this so that they can respect the old person's independence and yet handle him gently and firmly. If correct methods of lifting are explained and taught to the relatives, there is then no danger of back strain. Movement, activity and independence should be encouraged and made possible.

3. *To prepare old people for hospital*

Hospital admission is a major fear of all old people and is associated with death and dying. It is important that the nurse should explain why hospital treatment is necessary, discuss the hospital routine, and prepare the old person for hospital.

Many of these elderly patients come to the stage when they require prolonged and full nursing care during terminal illness. A night sitter-in service is available at these times. This scheme provides for the services of a night sitter or visitor to be supplied for patients who cannot be left alone at night and where there are no relatives available, to take turns in looking after the patient. It is also possible to provide a night sitter for one or two nights a week to give a relative a rest from continuous night duty with a patient.

During 1965 a night-sitter was arranged for 14 patients. As this service is allied to the home help service, a charge is made for all patients who are not in receipt of national assistance. It is for this reason that the service has not been fully used.

Home Helps

The home help service is an essential part of the Health Service and plays a large part in caring for the family in the home setting. Under the guidance of the health visitor, the home help can do a great deal to help the old people in their own homes. Eighty per cent of all cases requiring assistance from a home help are aged 65 and over.

Health visitors are used to make the initial assessment of need and she is then able to advise the home help on the type of assistance required. Some old people require relief from all housework, another may need help with the daily preparation of meals, another help with shopping. Home helps are expected to clean the home, cook, shop and help with laundry and mending.

There is every evidence that the home help service plays a vital part in the care of the elderly at home and without such a service, many old people would be unable to stay at home.

It has been found that the employment of part-time home helps leads to greater flexibility, also many home helps are neighbours of the people for whom they work, and call in at evenings and week-ends over and above the hours for which they are paid.

In 1964 a careful review was made on various aspects of the home help scheme. In order to learn at first hand the type of service provided, the County Nursing Officer and I visited homes of old people where home helps were working. A cross section of the County was so covered and the health visitor responsible for the home care of the old person accompanied us on our visits. It was gratifying to see the high standard of care provided by the home helps and to note the keen interest they took in their work.

The health committee considered certain aspects of this review and recommended:

(i) that patients on national assistance should not in future be assessed and charged for home helps;

(ii) that home helps should be issued initially with a nylon overall and a special county home help badge;

(iii) that approval be given to the principle of appointing home help organisers to assist the health visitors, especially in recruitment and control of home helps.

For the past two years in-service training has been arranged for home helps in Berkshire. A start was made in 1964 when two study afternoons were arranged in all districts. The topics discussed included the work of the Local Health Authority and the special responsibilities of the home help service, ethics of visiting in the home and the needs of the aged and ill persons, how the home help can act as a teacher to the families she visits, whilst one session was left to answer questions raised by the home helps.

During 1965 discussions were held on the importance of a well balanced diet with special regard to the needs of the elderly, home safety and the prevention of accidents in the home and time was again allowed for answering questions.

All home helps have expressed their appreciation of these discussion periods. It is apparent that these have helped to stimulate the home helps' interest and pride in work, and such training will now be arranged once yearly.

C. Hospital Care

In the original Hospital Plan for England and Wales it was stated that where adequate supportive services were available the necessary hospital provision is achieved with about 10 hospital beds per 1,000 persons aged over 65. This report also mentions "that with the further development of active treatment and rehabilitation and fuller provision of services for the elderly outside hospital, this ratio should be adequate or more than adequate generally and should cover the provision required for the elderly confused, who do not need treatment in a psychiatric hospital".

The hospital pattern of the future will include an active geriatric unit in each district general hospital. Berkshire is served by active geriatric units in Oxford, Reading and Maidenhead, each with a Consultant Physician in charge.

It is essential that there should be close liaison between the hospital and the local authority. Except in the case of acute illness when an elderly patient must be admitted to hospital immediately, it is important to know the home background of the old person and to be fully aware of all the social needs. Most old people are admitted to hospital for a short period of rehabilitation

and then discharged back to their own home. In order to give continuity to the care of old people, whether at home or in hospital, and to achieve greater liaison with the hospitals, two health visitors have been appointed as geriatric health visitors. These two health visitors each work closely with the Consultant Physicians. One was appointed the 1st September, 1964, and is based in the Eastern part of the County and the other was appointed the 1st December, 1965, to work in the Northern part of Berkshire. Both health visitors work in the area that is covered by the Consultant Physician.

They act as liaison officers between the general practitioner, health visitor and the hospital staff. Their duties consist of pre-admission work for hospital, post-admission work while the patient is in hospital, and follow-up work when the patient is discharged home.

The pre-admission to hospital duties include visiting all old people who are on the waiting list for hospital or for whom a request for admission has been made. Visits are made to the general practitioners, and health visitors or district nurses. This arrangement of work has helped in the better selection of elderly patients who need to be admitted to hospital. It has been found that the geriatric health visitor has been able to expedite admission to hospital, if necessary, and she is able to give more concentrated visiting to some border-line cases.

When the old person has been admitted, the geriatric health visitor is able to visit them in hospital, thus acting as a link between hospital and home.

These visits are very reassuring to these old people, who realise that as soon as their treatment is completed they can return to their own home. Two weeks before the patient is due to be discharged, the geriatric health visitor ensures that the home is ready, that necessary care is available and that the general practitioner is informed of the arrangements. As soon as the geriatric health visitor is satisfied that all is well, she hands over the case to the health visitor or nurse.

It has been found that the geriatric health visitors are often used as a specialised health visitor for any worrying cases and she is frequently contacted by the general practitioners, health visitors and district nurses. It was found that some old people who were completely helpless in their own homes were active and helpful when in a day hospital. Both geriatric health visitors visit the hospital physiotherapy department regularly in order to assess how much the elderly are able to do for themselves. They then visit the home to assess the conditions and are able to discuss the capabilities of the old person with the health visitor or nurse and the patients' family.

The geriatric health visitors attend weekly meetings with the consultant physicians, medical social workers, ward sisters, occupational therapists, and physiotherapists. At these meetings plans are discussed for the patients return to home.

Both health visitors also have a close link with Welfare Officers regarding elderly people needing residential accommodation.

It is apparent that the appointment of these two geriatric health visitors has led to greater co-operation between all services who deal with the care of old people.

ADULTS

The first aim of the health and welfare services is to promote health and well-being, and to forestall illness and disability by preventive measures.

As a further small step in early detection, and in agreement with the Local Medical Committee, arrangements were made for all district nurses to

undertake routine tests on all patients nursed at home. Nurses are instructed to inform the general practitioner concerned as soon as an abnormality is discovered. The doctor then takes any action that he thinks necessary.

Routine urine testing on all patients was started on the 1st May, 1965, with the following results:—

(1) 15 patients were found to have albumen in the urine which required further investigation. In all 15 cases the condition was resolved after treatment.

(2) 1 patient was discovered to have sugar in the urine and was referred by the G.P. to a diabetic clinic. Further investigations proved this patient to be a diabetic.

CERVICAL CYTOLOGY

Some 2,500 women in England and Wales die each year from cancer of the cervix (neck of the womb). These deaths represent over 5% of all cancer deaths in women. Until recently the diagnosis of cancer of the cervix depended chiefly upon clinical symptoms and examination. The patient who complained of irregular or unusual bleeding or discharge from the vagina sought medical advice: if examination revealed the presence of the malignant growth this might be in a later stage with little chance of cure, or if advice was sought early the chance could be up to 75% or more.

Techniques are available whereby scrapings of cells from certain organs including the cervix can be examined microscopically to detect these early stages years before a cancer begins to develop. It is thus possible to give early treatment and prevent the onset of cancerous changes and achieve a 100% result.

The cervical smears can be taken either by the general practitioner in his own surgery, or special clinics might be set up for this purpose. Several G.P.'s in Berkshire are already undertaking this service for their own patients. Others find it difficult to offer the service and would welcome the establishment of special clinics.

With the support of the Local Medical Committee, it was decided to experiment with such a clinic in Wantage, using facilities at the local hospital. It is staffed by one of our women medical officers, one of the local district nurses, with the help of two voluntary workers.

Mothers with one or more children are advised to attend by the family doctor or by the health visitor.

Each patient has the breasts palpated, the cervix examined and the smear taken. Mothers who have suspicious symptoms or unhealthy cervix are referred to their family doctor. The smears are examined at the Pathology Laboratory at Oxford. A negative result is posted to the mother and to the family doctor. It is intended that a positive smear result will be referred direct to the family doctor for follow up.

The following table shows details of the attendances at this clinic according to parity, age and social group. During this period May to December, 1965, there were a total of 17 sessions and an average of 12 mothers attended each session.

Total Mothers Attending: 182.

According to parity		*Approximate percentage*
Para 0	9	5
Para 1	41	22·5
Para 2	72	40
Para 3	39	21
Para 4	13	7
Para 5+	8	4·5
	182	100%

According to age groups		*Approximate percentage*
24 and under	8	4·5
25–29 years	13	7
30–34 years	60	33
35–39 years	44	24·25
40–44 years	33	18
45–49 years	15	8·25
50–54 years	7	5
55–59 years	2	
60 and over	—	—
	182	100%

According to social group		*Approximate percentage*
Social class 1	48	26
Social class 2	70	38·5
Social class 3	50	27·5
Social class 4	13	8
Social class 5	1	
	182	100%

It is interesting to note that 64% were mothers in social class 1 and 2, and 27% were mothers in social group 3. This is far from satisfactory since the incidence of cervical cancer is highest in social class 4 and 5.

It was therefore decided to undertake a survey in a housing estate in Wantage in order to discover reasons why mothers in social classes three, four, and five had not attended.

There were 216 houses on the estate 64% of the families in social class three and 24% in social classes four and five.

Results of Survey

Total mothers visited—120.

Reasons for not attending		*Approximate percentage*
Apathy	30	25
Fear of test and result	12	10
Difficulty with transport	Nil	Nil
Difficulty with care of children	2	1
Illness	7	6
Had test done elsewhere	14	12
Had not heard of clinic	55	46
	120	100%

The experience gained following this pilot scheme in Wantage has been invaluable and further clinics will be started in 1966. So far the clinic has not been advertised widely, and following the results of the survey undertaken in one housing estate, more publicity will be given to any future project.

NURSING CARE TO THE PHYSICALLY HANDICAPPED

Most of the patients between the ages of 20–60 years, cared for by district nurses, are those suffering from some form of physical handicap. These younger patients are suffering from such conditions as disseminated sclerosis, paralysis after poliomyelitis, progressive muscular dystrophy, and hemiplegia. Patients who have had "strokes" can be nursed at home most successfully and are able to return to a normal active life. To achieve this success, it is important that the nurses are able to spend time in the re-habilitation of their patients.

In order to ensure that all nurses and health visitors have sufficient knowledge to help with remedial exercises and rehabilitation, arrangements were made for them to spend a half day in the physiotherapy department of a hospital.

Such nursing requires competence with nursing skills and it is important that the nurse has an understanding of the needs of her patients. Patients require sympathy, understanding and compassion more so today with our complex civilisation than ever before. The home nurse must also remember the effect such illness can have on the family, as well as helping the patient to adjust herself to live under the conditions imposed by it.

The following case history illustrates the "total patient care" required when nursing a handicapped person at home.

"Mr. A. aged 46, suffered from a tumour of the brain—known to be cancer. He had been nursed at home since 1962 with paralysis of the right side of his body. His wife had twice been treated in a mental hospital for a neurosis and she required much help and support. The district nurse, who in this instance was also a health visitor, provided nursing care and she was able to enlist help from other agencies as follows:

(i) Financial help from the National Assistance Board.
(ii) Bath rail and an extra handrail on the staircase from the Welfare Services Department.
(iii) A television set from the National Society for Cancer Relief.
(iv) Home help through the Council's scheme.
(v) A night "sitter in" through the Marie Curie Nursing Scheme.

(vi) Nursing equipment:
Hospital bed
Pole and chain
Oxford lifting hoist
Wheel chair
Commode
Cantilever bed table
Sheepskin

In February, 1964, it was decided by the general practitioner that the nursing care was too heavy to be continued at home, and arrangements were made for Mr. A. to be admitted to a long-stay hospital. Unfortunately, Mr. A. was most unhappy away from home and after two days it was decided that he should return home for the last phase of his illness.

In April, 1964, he became very weak and was only able to take fluids by a straw. He was very emaciated and although a man six foot tall, he only weighed 4 stone. The nurse visited two or three times daily. In order to prevent bed sores, a sheepskin was provided. (The sheepskin allows currents of air to pass through its fibres, thus working on the same principle as a ripple bed). The sheepskin proved to be a great comfort to the patient and was instrumental in keeping this very thin man's skin healthy and intact.

In April the nights became a strain to the family, so a night sitter was employed three nights weekly.

Mr. A. became steadily weaker, and in May, 1964 he died."

In order to help these handicapped persons remain independent and to assist in the nursing care, equipment is provided. The following table indicates the variety of equipment used:—

Items in Use	*At the end of 1964*	*At the end of 1965*
Tripod sticks or other walking aids	129	249
Lifting hoists for the paralysed	21	14
Ripple beds for incontinent patients	9	14
Special beds	4	–
Mattresses	27	47
Hospital bed with pole and chain	18	35
Separate pole and chain	10	18
Bath safety rails	44	88
Bath seats	43	100
Gadgets for the arthritic	33	66
Sheepskins	–	26
Cantilever bed tables	–	21

HEALTH EDUCATION

According to the Cohen report on Health Education 1964 "the prime purpose is to promote mental and physical health". The contribution which health education should make to health has four main sub-divisions:

(1) Advice about specific preventive measures, e.g. vaccination and immunisation.
(2) Education with a view to inculcating habits and attitudes which will promote health and prevent disease, for example, refraining from smoking, preventing overweight, taking exercise.
(3) Education to understand the need for community-health measures and to support them. How to make full yet responsible use of all available health services, statutory and voluntary.
(4) Education to seek advice from the doctor at an early stage for certain conditions.

Much of the health education carried out in Berkshire is done as an integral part of the day to day activities of the domiciliary health services, both in visits to homes, and in clinic sessions. A programme of health education has developed slowly yet steadily during the past six years. This work has mainly been carried out by health visitors, who according to the Cohen report are at present the largest body of trained health educators. Reference has already been made (page 36) to their teaching work in schools; and (page 8) to work in antenatal and mothercraft classes.

The following projects have been carried out during the two years 1964 and 1965.

Club for Adolescent girls (after school leaving age)

Cressex Lodge is a home for adolescent girls who have been through juvenile courts and are on remand. We were approached by the Children's Officer asking if a programme of talks could be given to this group of 12 girls. After discussion with the Warden in charge it was decided that an area nursing officer would arrange a series of fortnightly evening sessions on the lines of a club. The girls' boy friends would be welcome if they liked to come and the evenings would conclude with refreshments and a social period.

The following programme was arranged:—

(i) Film on travel in England, followed by discussion of the aims and objects of the club and subjects that the girls would like.
(ii) Film "Learning to Live" followed by discussion on personal relationships.
(iii) Talk on make-up and demonstration by a Beauty Counsellor.
(iv) Film "Don't take the Risk"—subject venereal disease.
(v) Talk and discussion by a young policewoman.
(vi) Hairdressing demonstration.
(vii) Human responsibilities.
(viii) Film on work of U.N.I.C.E.F. "Three of our children".
(ix) Human emotions.
(x) Family life.
(xi) Standards of behaviour.

From the response shown it appears that these discussion groups have proved most successful.

MOTHERS AND PARENTS CLUBS

In 1961 twelve such clubs had been started, in 1964 this had increased to thirty-four, and in 1965 to thirty-six. It is interesting to note that the demand for such clubs is in the rapidly developing areas such as Sandhurst,

Crowthorne and Bracknell, and also in the very rural areas where the mothers feel somewhat isolated. In one rural area there is 100% attendance of the mothers, a total of sixteen in all. In other clubs it is usual for the attendance to vary between twenty and eighty.

A year's programme for one mothers club included the following subjects:—

(i) Personal hygiene, applying make-up.
(ii) Venereal disease.
(iii) The importance of vaccination and immunisation.
(iv) Childrens' reading
(v) Childrens' feet—shoes.
(vi) The dangers of smoking.
(vii) Early detection of cancer.
(viii) The significance of family and social relationships in the mental health of the community.
(ix) The emotional development of children.
(x) The relationship between adolescents and their elders.
(xi) Social services available.
(xii) Food values—how to prevent overweight.

In some parts of the County both father and mother attend these parents clubs. In one such club a full course of child psychology classes were arranged and the presence of both parents proved most helpful.

Club for mothers in Suffolk Lodge. County Council's Home for Mothers and Children

This club has met fortnightly since it was started in 1961. A similar programme is arranged as for mothers clubs in the county. In addition to the discussion groups on health education, demonstrations are arranged on simple home cooking.

FURTHER EDUCATION

Home nurses and health visitors have been asked to participate as lecturers in further education courses organised by the education department. Classes have been given on home nursing and first aid, and child psychology.

PRIVATE GROUPS

From time to time groups of private individuals have asked for talks on health education to be arranged. Two such groups have asked for a speaker to come and discuss the dangers of smoking and ways and means of stopping smoking.

Talks, lectures and discussions are given to any organisation requesting help.

Wherever health education programmes take place care is taken to include the following subjects:—

Cancer—so as to promote a truer understanding of cancer and the methods available for early detection and successful treatment.

Dental health education—to educate mothers in dental care so that they can inculcate good habits and dental hygiene to their children.

Danger of smoking—its established significance in lung cancer.

Healthy living—habits which will have a beneficial effect on health. Dangers of over-eating, the importance of exercise.

Venereal Disease—Discussion on the increase in venereal disease. The discussion is related to articles in newspapers and magazines.

With the steady development of health education it has been necessary to build up a large supply of visual aids teaching apparatus. In 1964, a printed book was produced so that all members of the health department were aware of the teaching aids available.

Although our health programme is developing, there is need for added emphasis in various fields. In order to keep abreast with this important aspect of work it is hoped that in the future provision may be made for the appointment of a Health Education Officer to strengthen our central organisation and secure greater support for publicity measures. Health Visitors would welcome the help, support and stimulus that would be more readily available.

The Health General Purposes Sub-Committee accepted the need for such an appointment but decided not to press for the establishment of the post in 1966/67 owing to current restrictions on expenditure.

HEALTH TEACHING IN SCHOOLS

The Newsom report "Half our Future" (1963) stressed the need for the final year of the school programme to be outgoing. Such a course should be an initiation into the adult world of work and of leisure, and an opportunity to strengthen links with the outside services. The "Cohen" report on Health Education (1964) recommended "that health education should be allocated periods in the schools syllabus, and that the contents of the schools' health education syllabus should be broadly based, aiming at giving the child such knowledge as would equip him to face the social and health problems he will meet in later years. Special health problems now needing particular attention in schools are education about the relationship of the sexes in all its human and social implications, including future responsibilities as parents, and the ill effects of smoking".

The participation of health visitors in health education programmes within the schools' syllabus since 1959 was described in the Annual Report for 1963. Forty health visitors are now undertaking this work in 30 secondary modern schools, 2 grammar schools and in 2 schools for the educationally subnormal. Only those health visitors who are interested in working with adolescents and who have expressed a desire to do this work are selected. Some form of inservice training is arranged each year for all health visitors who teach in schools. In May, 1965, a two-day course was held at Woodley Hill House. Three tutors from the Marriage Guidance Council spoke and acted as group leaders during the discussion periods.

The majority of schools ask the health visitors to take 1 year's course for school leavers, but in some schools health visitors are asked to take classes with the 11 year olds, the 13 year olds, as well as the school leavers.

The following subjects are always included in the health education programme:—

(i) the physical and emotional development of the child from birth to 5 years;
(ii) the physical and emotional development of the school child;
(iii) physiology and hygiene of menstruation;
(iv) the emotions and physical changes of adolescence;
(v) friendships, personal relationships, boy and girl relationships;
(vi) accepted behaviour patterns, the importance of respect to one another;
(vii) engagement and marriage;
(viii) illegitimacy—talk on social services;
(ix) venereal disease;
(x) the importance of a home and the influence of a family;
(xi) outside interests, youth clubs, Duke of Edinburgh Award Scheme, helping others, especially the elderly;

(xii) home safety and how to prevent accidents;
(xiii) smoking—risks to health;
(xiv) discussion on addictive drugs;
(xv) personal hygiene including foot hygiene;
(xvi) dental health;
(xvii) mothercraft talks—care of the young child.

The role of the health visitor is that of a skilful group leader—remaining free from dogmatism. She tries to lead and inspire their thoughts and conversation, thus helping them to form and think out for themselves "right decisions" on the basis of thought for others.

In agreement with the Director of Education, this work carried out among girls was extended to include the boys during 1964, the teaching and counselling being done by school teachers. In one mixed secondary modern school the head teacher and the health visitor arranged an experimental course for boys and girls. It was thought that this group should not exceed twelve in number and that the age group should be for those between fifteen and sixteen years. The idea of this course is to promote mutual understanding between boys and girls of their physical nature, their emotional problems and moral issues.

During 1965 it was decided to introduce talks on health education in one primary school. The health visitor, after consultation with the head teacher attends weekly and covers the following subjects in her syllabus:—

(i) care of teeth;
(ii) personal grooming;
(iii) care of feet;
(iv) care and protection of eyes;
(v) how to prevent infection;
(vi) home safety and prevention of accidents;
(vii) personal hygiene—positive health;
(viii) food values, why we eat different foods;
(ix) simple anatomy and physiology, including physiology of menstruation;
(x) elementary human biology.

The class is made up of 40 boys and girls; they are most attentive and look forward to this weekly class and discussion. Much use is made of visual aids and films.

In every school the health visitor concerned takes at least one session on the risks to health of smoking. Private and public schools in Berkshire have also asked for speakers on this subject and health visitors undertake to do this. At one public school over 100 boys attended voluntarily. These boys were most interested in the flannel-graph shown, also in the figures and statistics. Following this talk the boys are now preparing to set up an exhibition on cancer.

In summarising, the health education carried out in schools, it is hoped that we are able to help these young people to attain independence as a mature personality, to establish satisfactory personal relationships and to come to terms with changing emotion and emerging sexual powers. It is also hoped that it may be possible in some small way to prevent the illegitimate children and the problem families of the next generation.

HEALTH CENTRES

There is one Health Centre in the county and this is situated in Faringdon. It was established in 1951 in premises which were previously the Faringdon Cottage Hospital. The building requires improvement and further adaptation to bring it up to modern standards, and plans are being prepared.

Facilities are provided for four local general practitioners who provide medical services under Part IV of the National Health Service Act. The following Local Authority Clinics were held at the Centre during 1965:—

A Child Welfare Centre twice a month.
An Ante-natal and Post-natal Clinic twice a month.
A Relaxation Clinic once a week.
An Immunisation Clinic once a month.
A Dental Clinic twice a week.
An Ophthalmic Clinic once a month.

The Centre was also used on a number of occasions as a School Health Clinic, whilst a Regional Hospital Board Chest Clinic was held in the premises on two mornings.

There is rapidly growing interest amongst general practitioners in the health centre concept, and preliminary discussions have taken place in several areas of the county. The principle of joint provision has been accepted by the County Council, and in the last revision of the Health Committee's 10 year plans reference to all clinic projects has been amended to refer to either "health centres or clinics with accommodation for group practice surgeries."

At Didcot plans are being prepared for a clinic embodying surgery provision for a group of three doctors and for a dentist. Following an approach by both firms of doctors in Wantage the Health Committee, the Local Executive Council and Oxford Regional Hospital Board have agreed in principle to the erection of a health centre in the grounds of the local hospital. Consideration is also being given to the inclusion of surgery accommodation at Abingdon, Maidenhead and Windsor.

Bracknell new town is of particular interest. Following the decision to expand Bracknell to twice the originally planned size members of the Bracknell Development Corporation, the Local Executive Council and Health Committee met and decided not to lose the opportunity to plan health and medical services in the new (southern) half of the town.

A working party consisting of officers of the Development Corporation, Executive Council, Local Medical and Dental Committees, North West Metropolitan Regional Hospital Board, the District Medical Officer of Health and the County Medical Officer, has met together with Dr. Adams of the General Practitioner Advisory Service and the Divisional Medical Officer of the Ministry of Health. In the early meetings it was concluded that the balance of advantage lay in concentrating facilities in one health centre in the southern extension area, rather than the original idea of a number of small units one in each neighbourhood. Most interesting was the feeling that even at this stage a health centre was not an impossibility for the original (northern) area. Whether this can be formed around the nucleus of the existing clinic, or whether a completely new building will be required is not yet known.

DENTAL HEALTH

Mr. Jacob, Chief Dental Officer, reports:—

During the past two years some progress has been made in the number of pre-school children seen and treated, particularly in the number of teeth conserved. There has also been a small increase in the number of mothers seen and treated. This general increase has been mainly brought about by the closer co-operation between the Dental staff and the Child Welfare staff in those clinics where the two are working together. It is difficult to see much expansion in the number of mothers to be seen and treated as so many have their own private practitioner and naturally they stay with him. But it is always much more difficult for the parents to get their very young children seen through the General Dental Service and that is where our main work lies.

The two Dental Auxiliaries we have are of great value in the treatment and handling of pre-school children, and I feel this is proof of the excellent training they receive and their ability to handle very young children.

A great deal is heard these days of the shocking conditions of children's teeth but I myself feel that compared with prewar days there has been a vast improvement, particularly in the attitude of parents seeking treatment for their very young children and their co-operation in having conservative work done.

We have an ambitious programme for building new clinics in the coming years and as these come into use I am sure our Maternity and Child Welfare Dental Service will continue to expand.

DISTRIBUTION OF WELFARE FOODS

The arrangements for the distribution of "Government" Welfare Foods continued as in previous years, and at the end of 1965 there were 252 distributing points, 92 of these being Child Welfare Centres.

The issues of National Dried Milk, Cod Liver Oil, Orange Juice and Vitamin Tablets are compared with the issues during the two previous years.

Year	*National Dried Milk (tins)*	*Cod Liver Oil (bottles)*	*Orange Juice (bottles)*	*Vitamin Tablets (packets)*
1963 ..	61,433	7,643	122,465	12,638
1964 ..	61,500	7,373	140,677	11,799
1965 ..	58,234	7,618	153,382	10,969

The provision of these supplements as a wartime measure undoubtedly contributed materially to the improved nutrition of babies and young children. Whether they are necessary 20 years after the end of the war is more questionable. The County Council consequently suggested to the C.C.A. that the Ministry of Health be asked to review their policy in the light of the ready availability of proprietary milks and vitamins. This the C.C.A. agreed to do.

The Health Committee also gave considerable thought to the sales of proprietary preparations by volunteer workers in child welfare centres. It was concluded that the system was somewhat out of hand and in some cases was masking the proper function of the centres. A compromise was arrived at whereby each centre could sell a limited range of foods. Each is given freedom to choose their own brands not exceeding:

National Dried and not more than 2 proprietary dried milks.

Cod liver oil and 1 proprietary Vitamin A and D preparation.

Orange juice and 1 proprietary Vitamin C preparation.

Not more than 2 weaning foods.

Contrary to expectation this has not resulted in any falling off in clinic attendances, and health visitors are already finding that it is easier to organise teaching activities and that more mothers seek their advice.

PREVENTION OF ILLNESS, CARE AND AFTER CARE

There are a number of services provided under Section 28 of the Act. Several of these have been described elsewhere in this Report and include accounts on health education and chiropody. The services connected with the control of tuberculosis are described under the infectious diseases section whilst there is a separate section on mental health.

Recuperative Holidays

Convalescence of a recuperative type can be provided for persons not requiring medical or nursing care. During 1964 a total of 12 convalescent patients were admitted to seven holiday homes and their average length of stay was two weeks.

In 1965 there were 14 convalescent patients admitted to holiday homes and the average stay was again two weeks.

Loan of Nursing Equipment

The number of patients in receipt of equipment during 1965 was 660 compared with 397 in the previous year. Items loaned included lifting hoists, ripple beds, wheel chairs, mattresses and various walking aids. Provision has also been made for the supply of incontinence pads for the use of patients being nursed in their homes.

In July, 1964 a decision was made to discontinue the charges previously made to patients for the loan of these items of equipment.

Tuberculosis

Arrangements for the care and after care of persons suffering from tuberculosis are centred on the chest clinics under the direction of the three chest physicians. There are five tuberculosis health visitors on the Health Department staff working closely with the chest physicians and they advise on the prevention of the spread of the infection; on arrangements for care and after care and assist in the supervision of close contacts. More details of this service are given in the section in the Report concerning infectious diseases.

B.C.G. Vaccination

Arrangements have been made for the vaccination with B.C.G. of persons who are contacts of tuberculosis, school children aged 13 years or older and students who are attending training colleges, technical colleges and establishments for further education. Details of the B.C.G. vaccination scheme for school children are given elsewhere in this Report.

CHIROPODY SERVICE

The County Council continued the policy of making grants to voluntary organisations providing a chiropody service for aged and disabled persons.

In 1963 the annual grants were based on a sum of 2s. 6d. for each treatment carried out but this sum was raised to 3s. 6d. in 1964. At the same time

a further grant of 6d. a treatment was also allowed towards the costs of dressings where these had been provided. By the beginning of 1965, however, it was apparent that this grant, together with the patient's contribution of 2s. 6d. a treatment, was only just sufficient to cover the fee paid to the chiropodist by the voluntary organisation.

In May, 1965 a special section of the Health Committee considered the development of the chiropody service and the difficulties being experienced by the voluntary organisations. It was decided to increase the grant to 4/– for all treatments and to discontinue the payment of the additional 6d. for dressings. At the same time it was agreed that provision should be made to enable financial assistance to be given in special circumstances to voluntary organisations for the cost of hiring halls and rooms for chiropody clinics.

Treatments

10,210 treatments were given at 41 centres in the county during 1964. In 1965 this figure rose to 13,000 and the number of centres increased to 44. The service will continue to expand and it is expected that over 14,000 treatments will be carried out in 1966. Even so, the existing centres will not provide an adequate service for the whole of the county and there will still be some areas where there is no service at all. The extension of the service is limited to some extent by the lack of suitable clinic premises and the shortage of qualified chiropodists.

There also appears to be a need for a domiciliary service. Many of the local voluntary organisations already make arrangements for domiciliary treatments but it is usually necessary to pay the chiropodist as much as 15/– for each domiciliary treatment whilst the county grant would still be 4/–. No additional grants are paid in respect of such treatments nor are any grants made towards the cost of the transport of patients to the chiropody clinics.

Chiropodists

New grants to organisations are now only made when the chiropodist they employ is registered in accordance with the "Professions Supplementary to Medicine Act, 1960." Unfortunately there appears to be a shortage of suitably qualified chiropodists in the county.

There would now appear to be considerable advantage in appointing a chiropodist to the staff of the Health Department. It would then be possible to complete a survey of existing arrangements in the county, co-ordinate the services at present provided, undertake a pilot scheme for a county domiciliary chiropody scheme and provide information to assist in the planning of an extended chiropody service in the future.

REGISTRATION OF NURSING HOMES

The Public Health Act, 1936, requires the registration of nursing homes by the County Council. These provisions also applied to mental nursing homes but were modified by the Mental Health Act, 1959 and the Mental Health (Registration and Inspection of Nursing Homes) Regulations, 1962.

In past years it was generally considered that the legislation provided under the Public Health Act for the inspection and registration of nursing homes was inadequate and the introduction of the Nursing Homes Act, 1963 was welcomed. This Act authorised the Minister to make regulations as to the standards of nursing homes and was followed by the Conduct of Nursing Homes Regulations, 1963.

The present regulations came into operation in August, 1963 and deal in

detail with the provision of facilities and services, staffing and the maximum number of patients allowed in the nursing homes. At the same time, nursing homes (whether run for profit or not) are now subjected to similar rules governing the conduct of residential homes for disabled and old people and nursing homes for the mentally disordered.

Registrations in 1964

There were no new registrations during 1964 and, at the end of the year, 11 nursing homes were registered and these provided a total of 241 beds. Two of these nursing homes were registered as mental nursing homes.

Registrations in 1965

Four new nursing homes were registered in 1965 and, at the end of the year, 15 nursing homes were on the register (including two mental nursing homes) and these homes provided a total of 323 beds.

Inspection of Homes

Routine inspection of these homes were undertaken by members of the department's medical staff and it was usual to visit each home twice during the year.

MEDICAL EXAMINATION OF STAFF

Until 1st April, 1965 it was the practice for persons appointed to the staff of the County Council to be medically examined prior to taking up their appointment. There were two main reasons for this medical examination—first to ensure that the person concerned was fit to undertake the work for which he was appointed, and secondly to ensure that he was not suffering from a disability or illness which was likely to cause him to be an undue liability on the Council's superannuation fund.

At the end of 1964 approval was given to a recommendation that successful applicants for employment with the County Council should, in future, complete a medical questionnaire instead of undergoing a medical examination. This scheme was put into practice on 1st April, 1965 and, since that date, completed medical questionnaires have been scrutinised by a medical officer and full medical examinations were undertaken when this appeared necessary.

Medical Examinations Undertaken During 1964

During 1964 a total of 271 persons were medically examined prior to taking up an appointment with the County Council. 208 of these examinations were carried out by medical officers on the Health Department's staff.

Medical Examinations During 1965

In the first three months of the year 58 medical examinations were undertaken.

Medical Questionnaire Scheme

From 1st April, 1965 until the end of the year, 537 completed questionnaires were passed to the department for scrutiny by a medical officer. 498 persons were recommended for admission to the Council's superannuation scheme whilst the remaining 39 persons were considered to require a full medical examination before any recommendation could be made.

After medical examination it was considered that 4 of the 39 persons should be placed in Category A.1.

Recommendations made in respect of the other 35 persons were as follows:—

24 persons (category A.2)—Those who are in good health, but possess defects which are not likely either to shorten the full term of active service or to interfere with efficiency.

5 persons (category B.1)—Those who are in good health at the time of the examination and may reasonably be expected to render effective service for a substantial period, though they suffer from permanent defects likely to shorten the full term of active service.

6 persons (category B.2)—Those who are in good health, but suffer from defects which are likely to interfere, to some extent with efficiency, though they are not serious enough to make the candidate unfit.

There is no doubt that the introduction of the medical questionnaire has simplified procedure as far as the Health Department is concerned and has resulted in a considerable reduction in the number of medical examinations undertaken by the medical staff in the department. This scheme has come at an opportune time in view of the larger number of applicants entering the Council's employment compared with previous years, and the shortage of available medical officer time.

ROAD TRAFFIC ACT, 1960

During 1964, 19 cases were referred to the County Medical Officer for an opinion in respect of fitness to hold a current driving licence. Of these, 11 persons were considered to be medically fit and eight were considered to be unfit to hold a driving licence.

In 1965, 32 cases were referred for opinion. 25 persons were considered to be medically fit to hold a licence to drive a motor vehicle whilst seven persons were unfit. Four of these seven were suffering from epilepsy, two had a mental illness and one had a physical disability.

AMBULANCE SERVICE

Once again the mileage covered and the patients carried by the ambulance service show an increase over previous years. Statistics relating to the service can be found in Table 7 in the Appendix. The number of patients conveyed in 1964 showed an increase of 8,183 over the 1963 figure, whilst the 1965 figure showed a further increase of 9,862. The average ambulance mileage per patient was 8·1 in 1964 and 7·8 in 1965. Over 86 per cent of the patients were taken to hospital out-patient clinics or other out-patient departments, and this group of patients is mainly responsible for the continual increased demand on the service year by year. It is interesting to note during both years that there was actually a decrease in the number of accident and emergency cases taken to hospital.

Hospital Car Service

The Hospital Car Service again continued to deal with a large proportion of the sitting cases. The following figures show the work done compared

with the previous years.

Year	Number of Journeys	Number of Patients	Mileage
1963	22,367	35,316	734,567
1964	25,848	38,795	799,005
1965	28,824	45,588	896,153

There were 120 drivers available for duty during 1964–65.

Only five years ago the number of patients carried was less than 29,000. If the present rate of increase continues the 1966 figure will be over 50,000.

Staffing and Vehicles

The full time staff employed at the five main ambulance stations and five sub-stations consisted of:—

2 station officer-controllers; 3 station officers; 5 deputy station officers and 65 driver-attendants.

In addition there was 1 ambulance controller and 7 control clerks.

43 vehicles were in use during the period and they consisted of: 19 four-berth stretcher ambulances; 19 dual purpose ambulances and 5 sitting case ambulances.

It was in October, 1964 that 2 full time driver-attendants were appointed at Hungerford. A suitable duty room was made available at Hungerford Hospital and they work under the direction of the West Berks Control at Newbury.

Consideration was given to the most suitable type of warning device for common use on ambulance, fire and police vehicles and it was decided that the two tone horn was more effective than either the bell or the siren. As a result all ambulance vehicles have now been fitted with these two tone horns.

During 1965 the estate car ambulance purchased at the end of 1964 was put through extensive trials at all the main ambulance stations and from reports received and statistics prepared it transpired the stretcher arrangements on the vehicle were rather impracticable. Consequently the vehicle was virtually restricted to the carriage of sitting patients. After considering all the facts it was decided to replace the Morris Minor sitting case cars with Ford Zephyr cars which were larger and more comfortable and also had a larger carrying capacity. The remaining four Morris Minor cars were replaced with Ford cars in December, 1965.

Staff Meetings

A meeting between the station officers, the County Ambulance Officer, the County Medical Officer and his Deputy, was held in April, 1964 and this meeting enabled the station officers to express their views and opinions on matters affecting the service. This was found to be extremely valuable and three further meetings have since been held. Matters discussed have led to procedures introduced and decisions taken on such items as inflatable plastic splints, disinfection of ambulances, stretcher design, resuscitation apparatus and equipment in vehicles.

Development Programme for Ambulance Stations

Newbury—The vehicle accommodation at Newbury Ambulance Station was found to be inadequate and it was decided that the accommodation should be increased to meet the present and future requirements. It is anticipated that the work will be completed during 1966.

Windsor—The projects for the erection of a new ambulance station at Windsor suffered a delay owing to the government's restriction on building

projects and it is not anticipated that work on the new station will commence before the latter part of 1966. As the site of the present ambulance station was required by the Education Committee for the rebuilding of the College of Further Education it was decided to take over the old fire station at Windsor as temporary accommodation.

Didcot—A site for the construction of a new ambulance station, multi-purpose clinic and group practice centre was acquired in The Broadway, Didcot. A firm of private architects has been appointed and plans have been prepared for the erection of the ambulance station.

Review of the County Ambulance Service

As a result of a number of applications in respect of increase in pay and upgrading by control staff, station officers and their deputies throughout the county, the Health Committee decided to set up a working party to carry out a general review of the County Ambulance Service.

This working party held its first meeting in April, 1965. It consisted of the Deputy County Medical Officer as Chairman, the Administrative Officer, the County Ambulance Officer and an officer from the Joint O & M Unit, and its terms of reference were as follows:—

"To review the functions, organisation, operating methods, facilities and staffing of the County Ambulance Service and to make recommendations generally regarding the improvement of the Service."

The working party, during the course of its investigations, made contact with all members of the staff of the County Ambulance Service, the Trade Unions, the Hospital Car Service, the various different Hospital Authorities and the voluntary bodies. Amongst the items considered were the following:—

(a) Standard of service
(b) Staffing of the service and a supervisory structure
(c) Ambulance control and control staff
(d) Provision and location of stations
(e) Establishment and purchase of vehicles
(f) Hospital Car Service
(g) Staff training
(h) Use of volunteers
(i) An improved scale of uniform issue
(j) The setting up of a joint consultative committee
(k) Arrangements with other ambulance authorities.

The report of the working party was completed in October, 1965 and the final recommendations were first considered by the Health Committee in December of that year.

MENTAL HEALTH SERVICES

Public health measures and advances in treatment have brought an increasing number of infectious diseases and major physical ailments under control. Problems of mental disorder have in consequence become relatively more prominent, and mental illness is now responsible for a major part of the community's illness and absence from work as well as individual and family unhappiness.

Mental Illness

Mental illness includes a wide range of different disorders. For many treatment now offers a hopeful outcome, but for only few have we sufficient

knowledge about causation to enable us to apply preventive measures. Some emotional disorders can be traced back to faulty personal and intra-family relationships and, although this has yet to be demonstrated, it would seem that many of these could be prevented by suitable teaching. The work of the home-making classes in schools referred to on pages 36 and 37 could make a big contribution here, and it is also to be hoped that the work of the child guidance clinics (see pages 82 - 88) will prevent some mental disorder in later life.

Adolescents

A further big step was taken with the opening of South Field in July, 1965. This was built adjacent to the Education Committee's Field House Hostel at Wokingham and is under the joint direction of the same warden. In the past some girls had to leave Field House when they left school because the Education Committee had no power to provide care beyond this point. Now it will be possible for girls who have started work, but who cannot return to their own homes or who are not yet ready to live independently, to live in South Field and continue to receive help from the staff whilst taking further steps to independence. The Health and Education Committees agreed to set up a Joint House Committee to look after both hostels. This has enabled the staff to work a co-ordinated yet more flexible admission policy, it being mutually agreed that on occasion certain girls still receiving full-time education can transfer to South Field if they are sufficiently mature, or conversely an immature girl leaving school at 15 could be kept temporarily in Field House.

Adult Mentally Ill

A large, although varingly estimated, proportion of patients consulting their own doctors are suffering from illness of emotional or mental origin. Some will be referred by their doctors to psychiatric out-patient clinics, and a few may subsequently be admitted by direct arrangements without any help from the mental welfare officer. An increasing number are being referred for help however. As against 389 referrals in 1963 there were 594 in 1964 and 600 in 1965. Mental Welfare Officers were concerned in the following hospital admissions in accordance with the appropriate sections of the Mental Health Act, 1959:—

	1964	*1965*
Section 5 (Informal admission)	106	108
Section 29 (For observation, 72 hours)	139	160
Section 25 (For observation, 28 days)	44	44
Section 26 (For treatment)..	21	13

At the end of 1965, 159 patients were being helped by mental welfare officers. All except one were over the age of 16. 148 were receiving home visits whilst 11 were residing in residential homes or hostels at the local authority expense. There were no mentally ill patients on the waiting-list for admission to hospital.

Halfway Homes

The Council's development plans include a halfway home to act as a stepping-stone for certain patients who no longer require full hospital treatment, but who are not quite ready for full return to community life. The Health Committee had hoped to acquire Sherwood House when vacated by the move of the Children's Department to Abbey Mill House, but owing to the change in plans for the new Shire Hall, this accommodation has not yet become available.

Social Clubs

Many patients find difficulty in mixing and making social contacts, especially on first discharge from hospital. Social clubs can be invaluable in the rehabilitation of these patients and in preventing breakdown and re-admission. Through the initiative of the mental welfare officers in North Berks and with encouragement and practical support from Dr. Pomryn of Littlemore Hospital, the first of such clubs was started in Abingdon towards the end of 1965, and it is hoped that similar ventures will be made in other areas.

Mental Welfare Officers

In 1963 the first summary of local authority 10 year plans showed that the ratio of social workers per 1,000 of the population in Berkshire (0·03) was only half the national average (0·06) and by 1972 the comparison would have been even more unfavourable (0·03 per 1,000 in the county compared with 0·1 per 1,000 nationally). As a result of these comparisons it was agreed that there should be additional appointments of two mental welfare-welfare officers in 1964 and further additional appointments in future years. Approval was also given to a training scheme whereby two trainee social workers are appointed each year and seconded to two-year courses leading to the Certificate in Social Work. By the end of 1965 there were seven senior mental welfare officers, four social workers, two welfare assistants and five trainees in the Health and Welfare Departments.

Psychiatric Social Workers

The County Council had for some years been paying a proportion of the salary of one of the P.S.W.s at Fair Mile Hospital. In 1963 the Council agreed with the Reading Hospital Management Committee to make a joint appointment of a P.S.W. post to cover work with Berkshire patients attending the out-patient clinic in Reading. Although we had not succeeded in filling the latter post it was agreed to extend the principle and to have four such posts in the county all jointly with appropriate Hospital Management Committees. In October, 1965 we succeeded in recruiting two P.S.W.s, one to the post with the St. Birinus Hospital Management Committee and one with the Reading Hospital Management Committee. It was however agreed that instead of one P.S.W. devoting herself to in-patient work and the other exclusively to out-patient work, continuity of care would be better achieved by both undertaking a full range of duties in the Fair Mile catchment area. It had been hoped to make a third appointment with St. Bernard's Hospital, Southall, but owing to technical difficulties this was not immediately possible, and one of the posts is being held jointly by a P.S.W. working partly in the adult community field and partly in the child guidance clinic. This will provide another very interesting experiment in co-ordination of services.

Mental Subnormality

Subnormals have, for historical reasons, received less than their fair share of help throughout the country. We still tend to under estimate their capabilities.

The child used to be called "mentally defective". It was early realised that, like the blind child, he could not benefit from education at an ordinary school, but it was assumed that he was completely incapable of benefiting from any education and responsibility passed from the education to the health authority. So-called occupation centres were set up in many areas. These relieved parents of the strain of constant care and also provided some useful social training. Where no facilities existed or there were super-added social difficulties these children were often admitted to hospital, where they remained

for the rest of their lives. Following the Report of the Royal Commission and the consequent Mental Health Act of 1959, it was realised that many did not need long-term residential care within a hospital setting and that our aim should be to keep such people in the community. We are also beginning to realise that these children can indeed benefit tremendously from education in its broadest sense.

Purpose-built buildings, with the full facilities of any school, are now being erected throughout the country. Although in Berkshire we have been slightly slower off the ground we are well in the van of forward thinking. Not only are the staff (previously referred to as supervisors) called teachers but the buildings are referred to as training schools instead of the outmoded term "junior training centres."

Training Schools

At the beginning of 1964 there were two schools in the county, at Bracknell and Newbury, providing 73 places. It was appreciated that the new school at Abingdon would not be built until the latter part of 1965 and consequently arrangements were made for use of temporary premises in Saxton Road, Abingdon. We are grateful to the Civil Defence Committee for allowing us occupation. This temporary school, which opened on 21st September, 1964, provided places for 20 children and two teachers were appointed to work under the direction of the headmaster of the nearby Tesdale (E.S.N.) School. Eight of the children had previously attended training centres in other local authority areas whilst 12 previously remained at home. At the end of 1964 all 20 places remained filled and there were a further five children on the waiting-list.

By the time the new school in Radley Road was ready for occupation, the committee was so impressed with the initial results of the link with Tesdale School that an approach was made to the Education Committee to make a joint appointment of headmaster for this and the new Bennett House School. To this the Education Committee willingly agreed. This particular experiment, believed to be only the second in the country, will be watched with special interest.

At the same time the schools at Newbury and Bracknell continued to function in premises that were not entirely satisfactory. Due to persistent staffing difficulties it was not possible for the Bracknell Junior Training School to function with all 50 places filled and an average of only 39 attended the school during 1964.

In May, 1965, the Newbury Training School moved from the Baptist Church Hall, Newbury to Donnington Lodge, Donnington. The school will remain in this building until the completion of a new school building in the grounds of Donnington Lodge. It is also hoped to form the nucleus of a weekly hostel for a dozen or so children living too far away to attend school daily.

It is disturbing to report that no site has yet been found for a new school to replace Coopers Hill School, Bracknell, although the Welfare Services Committee has agreed to relinquish land at Cannon Hill for the fourth school to serve the Windsor-Maidenhead area.

Adult Workshops

The only adult workshop and training centre in operation in the county at the beginning of 1964 was Maidenhead. This workshop was transferred from the Masonic Hall to "High Close," North Road, in October, 1964 and it then operated on a full-time basis with great success. Mr. Wood, Workshop Manager, reports:—

"The Berkshire County Council appointed a full-time supervisor on

14th October, 1963. The workshop was at that time operating on a half-time basis at the Masonic Hall, High Town Road, Maidenhead; hours 9.30 a.m. to 12.30 p.m. with an assistant part-time supervisor appointed by the County. A member of the Maidenhead Society for the Mentally Handicapped (who had been acting supervisor) relinquished his post. There were 18 workers (13 females and 5 males) attending at this time, some conveyed by Ambulance Car Service to the shop, others by a Hospital Car Service. In October, 1964 the workshop was transferred to High View, North Road, Maidenhead on a full-time basis. Due to the re-organisation, two workers who had been with us at the Masonic Hall were transferred to the Windsor area.

After settling down in our new premises three extra jobs were secured. One of these jobs being somewhat difficult for subnormal people it was necessary to acquire the use of pliers and screwdrivers. With perseverence over a period of three to four weeks results showed such good accomplishment that we were soon able to average about 150 articles per week to the suppliers."

Windsor – A second workshop was established in the Congregational Church Hall, William Street, Windsor in October, 1964 and 24 trainees were admitted. A manager was appointed at the workshop at its commencement but it proved impossible to appoint any instructors to help at the workshop during that year and the necessary assistance was given by voluntary workers.

Workshops in 1965 – A third workshop for subnormal adults was opened at Donnington Lodge, Newbury in December, 1965. The Headmistress of the Junior Training School acted as temporary part-time Manager of this workshop and a male instructor was also appointed. This workshop is in the same temporary premises as the Junior Training School and, until a new workshop is built, only 16 adults can attend.

At the end of 1965 the three workshops provided places for 86 subnormal adults.

Home Teachers

There were three home teachers on the staff and they visited those subnormal persons who were not attending training schools or workshops. They are all trained occupational therapists and I am grateful to Miss J. Cooper, the Senior Home Teacher, who reports:—

"During 1964 the three Home Teachers made over 2,100 visits to 60 patients, so providing a service to all those patients who were, for various reasons, unable to attend a training centre or sheltered workshop, or who are in full-time remunerative employment.

Training is given in craftwork and in certain cases elementary educational subjects. In addition to visiting individual patients, group training is undertaken whenever possible in patients' homes, providing experience of working together and an opportunity of assessing their suitability for admission to a centre. Every effort is made to stimulate the patient's interest by providing pursuits outside the usual run of training activities, and these include nature walks, shopping, visiting local places of interest, brass rubbings, etc. Some patients have casual earnings from the preparation of motor taxation envelopes and driving licence covers.

The general day-to-day training of a handicapped person and all the problems that parents are faced with form an important part of the home teacher's visit. The parents are most co-operative and welcome the guidance and advice that is given on bringing up a handicapped child in the home."

In 1965 a number of children and adults were able to attend schools and adult workshops and the number of persons requiring home visits fell from 60 to 42 (7 children and 35 adults). All these persons were subnormal or severely subnormal.

As more schools and workshops are provided the need for home visiting will fall off still further. At the same time there are many physically handicapped and other patients throughout the county who would benefit from help from trained occupational therapists. The Health and Welfare Committees therefore agreed in principle to a joint service with the three existing staff and a new fourth home teacher, each covering a full range of work within a given area of the county. One of these will work closely with consultants and others in the Windsor Group Hospital catchment area, two within the Reading Hospitals catchment area and one in North Berks and linked with the Oxford hospitals.

Social Clubs

Voluntary organisations provided one social club for mentally handicapped children (Maidenhead) and two social clubs for mentally handicapped adults (Maidenhead and Windsor).

Statistics

86 persons were brought to the attention of the Authority during 1965 compared with 112 in 1964 and 95 in 1963.

24 persons were admitted to hospital care informally whilst 2 were admitted on a formal basis. Arrangements were also made for 38 children and 7 adults to have a period of short-term care in hospital.

At the end of 1965 there were 744 subnormal and severely subnormal patients under the supervision of the Authority as follows:—

	Children		
	Under 16	*Adults*	*Total*
Attending Schools or Workshops ..	134	99	233
Resident in Residential Training Care ..	—	3	3
Attending Residential Homes or Hostels	1	—	1
Receiving Home Training	7	35	42
Receiving Home Supervision	52	413	465

33 children and 6 adults were on the waiting-list for admission to hospital and were considered to be in urgent need of hospital care. In addition, a further 7 children and 6 adults were also awaiting hospital admission.

Mental Nursing Homes

The Public Health Act, 1936, Part 6 requires the registration by the County Council of nursing homes and these provisions are also applied, subject to modifications, by the Mental Health Act, 1959, Part 3 and the Mental Health (Registration and Inspection of Nursing Homes) Regulations, 1960, to mental nursing homes.

In 1964 and 1965 there were two registered nursing homes in the county providing a total of 23 beds for mentally disordered persons.

Residential Homes for the Mentally Disordered

There were four residential homes registered in the county in accordance with Section 37 of the National Assistance Act and Section 19 of the Mental Health Act. These homes have places for 112 persons.

As in the case of the mental nursing homes, inspections were undertaken by the Deputy County Medical Officer at regular intervals.

Plan of Capital Works for Development of Mental Welfare Services

(a) *Junior Training Schools*

Purpose-built schools will be required to replace temporary schools at Bracknell and Newbury within the next two years. A training school will also

be required in the East Berks area, probably in or near Maidenhead, during this same period of time. By 1967, therefore, four training schools should be available, providing a total of 170 places.

(b) *Hostels for Subnormal Children*

A hostel for children will be in operation in 1966 at Donnington Lodge and will provide places for a number of children attending the junior training school. These children will spend all weekends and school holidays at home.

(c) *Workshops for Mentally Subnormal Adults*

Further workshops are required at Abingdon and Bracknell and it is hoped that these will be available in 1968. The temporary workshops at Newbury, Windsor and Maidenhead will also require to be replaced and it should then be possible to accommodate 200 adults in these five workshops.

(d) *Hostels for Mentally Subnormal Adults*

Provision has been made for hostels at Bracknell (1966–67), Abingdon (1967–68), Newbury (1968–69) and Windsor or Maidenhead (1969–70). In addition, it is hoped to acquire a building for a small hostel in Maidenhead or Windsor in 1966–67 to provide accommodation for 10 adults. Altogether, places should be available for 106 adults in these five hostels.

Mental Health Statistics

Statistical details are given in Tables 5 and 6 in the Appendix.

APPENDIX A

HEALTH COMMITTEE AND SUB-COMMITTEES
(*As at December, 1965*)

Health Committee

Chairman
A. Arbuthnott, M.B.E., E.D.
Vice-Chairman
J. C. Norris, M.A.

Mrs G. I. Longworth
Mrs M. E. South
A. F. Banks, Esq.
Dr. R. Child
G. S. Dace, Esq.
S. S. Gates, Esq.
F. W. Haines, Esq.
Major H. Fairfax Harvey, M.B.E., M.C.
G. A. Hughes, Esq.
The Hon. Mrs. Dorothy R. Maclay
Mrs H. E. McCarthy
J. L. Sale, Esq.
D. W. Lansdown, Esq.
P. F. Murray, Esq.
F. J. Pratt, Esq.
Mrs M. L. Rugg
A. H. Spurway, Esq.
K. A. Smith, Esq.
Capt. M. F. Turner-Bridger
Dr A. G. Walter
Miss R. W. Ruth Whitehead
Mrs. M. F. C. Wood

Representatives of Other Bodies

H. K. Potter, Esq.
J. Goulding, Esq.
Lt. Colonel D. C. S. Sinclair, O.B.E.
Mrs. K. Dancy
Miss E. Rickards, M.S., F.R.C.S.
H. J. Eldred Hall, Esq.
Dr. J. Anderson Hill

Ambulance Sub-Committee

Chairman
A. F. Banks, Esq.

G. S. Dace, Esq.
S. S. Gates, Esq.
F. W. Haines, Esq.
F. J. Pratt, Esq.
Major H. Fairfax Harvey, M.B.E., M.C.
G. A. Hughes, Esq.
K. A. Smith, Esq.

Co-opted Members

Miss R. M. Young
W. G. Thomas, Esq.
Brig. T. E. D. Kelly, C.B.E.
Mrs M. Balding
W. E. Foster, Esq.
Miss O. M. Harris

Nursing, Maternity and Child Health Sub-Committee

Chairman
Miss R. W. Ruth Whitehead

Mrs. G. I. Longworth
The Hon. Mrs. Dorothy R. Maclay
Mrs. H. E. McCarthy
P. F. Murray, Esq.
D. W. Lansdown, Esq.
Mrs. M. L. Rugg
Mrs M. E. South
Mrs M. F. C. Wood

Co-opted Members

Mrs. K. Dancy
Mrs. A. D. Gardner
Miss D. M. Finch, O.B.E.
Mrs G. Howard

Mental Welfare Sub-Committee

Chairman

J. L. Sale, Esq., C.I.E.

Mrs. G. I. Longworth
The Hon. Mrs. Dorothy R. Maclay
Mrs. H. E. McCarthy
Miss R. W. Ruth Whitehead
D. W. Lansdown, Esq.
Mrs. M. E. South
Mrs. M. F. C. Wood

Co-opted Member

Miss M. E. Eyston

Health General Purposes Sub-Committee

Chairman

A. Arbuthnott, Esq., M.B.E., E.D.

A. F. Banks, Esq.
Dr. R. Child
G. S. Dace, Esq.
S. S. Gates, Esq.
K. A. Smith, Esq.
Major H. Fairfax Harvey, M.B.E., M.C.
G. A. Hughes, Esq.
F. J. Pratt, Esq.
A. H. Spurway, Esq.

Education Committee

Special Services Sub-Committee

Chairman

Mrs. M. E. South

Vice-Chairman

Mrs. J. P. Yeo

The Hon. John Astor, M.P.
R. H. Beer, Esq.
Miss E. M. Frodsham
Mrs. M. C. Long, M.B.E.
Miss K. L. Mackenzie
The Rev. T. W. Morcon-Harneis
Mrs. M. Whipple
M. W. Paine, Esq., M.B.E.
A. J. Rippon, Esq.
Mrs. M. L. Rugg
Mrs. B. E. Scott
Mrs. E. B. Sheasby
Miss C. M. Watson Smith
The Rev. A. E. Zollo

Co-opted Member

Mrs. K. Comyns

APPENDIX B

STATISTICAL TABLES

TABLE 1—POPULATION, BIRTHS AND DEATHS

	Population 1961	*Estimated Population 1965*	*Live Births* 1964	1965	*Deaths* 1964	1965
URBAN DISTRICTS						
Abingdon Borough ..	14,287	16,110	285	301	122	143
Maidenhead Borough ..	35,411	41,230	822	858	407	436
Newbury Borough ..	20,397	21,750	383	399	270	247
Windsor Borough ..	27,165	29,550	533	545	253	264
Wallingford Borough ..	4,833	5,470	132	106	100	94
Wantage	5,949	7,290	138	167	68	73
Wokingham Borough ..	11,392	15,880	307	363	153	184
Total	119,434	137,280	2,600	2,739	1,373	1,441
RURAL DISTRICTS						
Abingdon	30,321	34,570	698	658	248	258
Bradfield	27,905	34,600	713	841	236	239
Cookham	17,310	18,100	336	289	144	178
Easthampstead	43,192	53,750	1,091	1,140	363	366
Faringdon..	13,948	15,630	321	332	122	146
Hungerford	9,749	10,250	185	166	107	117
Newbury	19,562	21,710	544	427	190	193
Wallingford	19,092	20,910	462	516	230	232
Wantage	16,779	18,840	418	394	148	154
Windsor	15,665	17,220	270	265	185	215
Wokingham	51,260	65,090	1,383	1,513	497	476
Total	264,783	310,670	6,421	6,541	2,470	2,574
Administrative County ..	384,217	447,950	9,021	9,280	3,843	4,015

TABLE 2—BIRTHS AND DEATHS OF INFANTS 1964 AND 1965

1964

	Males *Total*	*Legit.*	*Illegit.*	Females *Total*	*Legit.*	*Illegit.*
Live Births	4,569	4,342	227	4,352	4,120	232
Still Births	62	57	5	54	50	4
Deaths of Infants						
Under 1 year ..	85	80	5	58	55	3
Under 4 weeks ..	57	55	2	41	38	3
Under 1 week ..	51	49	2	34	31	3

1965

	Males *Total*	*Legit.*	*Illegit.*	Females *Total*	*Legit.*	*Illegit.*
Live Births	4,786	4,517	269	4,494	4,246	248
Still Births	53	52	1	60	53	7
Deaths of Infants						
Under 1 year ..	78	73	5	50	45	5
Under 4 weeks ..	53	49	4	42	37	5
Under 1 week ..	46	42	4	35	31	4

TABLE 3A—CAUSES OF, AND AGES AT, DEATH, 1964

Causes of Death in County, 1964	Net Deaths in Age Groups of "Residents", whether occurring within or without the County											
	Age Groups											
	All Ages	Under 4 weeks	4 weeks under 1 year	1—	5—	15—	25—	35—	45—	55—	65—	75 and over
Tuberculosis, respiratory	8	—	—	—	—	—	2	1	—	2	1	2
Tuberculosis, other	2	—	—	—	—	—	—	—	—	1	—	1
Syphilitic disease	5	—	—	—	—	—	—	—	2	1	—	2
Diphtheria	—	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	1	—	—	1	—	—	—	—	—	—	—	—
Meningococcal infections	1	—	—	—	—	—	—	—	—	1	—	—
Acute poliomyelitis	—	—	—	—	—	—	—	—	—	—	—	—
Measles	—	—	—	—	—	—	—	—	—	—	—	—
Other infective and parasitic diseases	5	—	—	—	—	1	—	—	1	—	—	3
Malignant neoplasm, stomach	76	—	—	—	—	—	1	4	4	18	21	28
Malignant neoplasm, lung, bronchus	209	—	—	—	—	—	1	9	24	95	53	27
Malignant neoplasm, breast	89	—	—	—	—	—	1	6	17	25	18	22
Malignant neoplasm, uterus	24	—	—	—	—	—	—	1	7	5	8	3
Other malignant and lymphatic neoplasms	374	—	1	3	3	2	10	20	32	74	110	119
Leukaemia, aleukaemia	24	—	—	3	2	1	2	2	1	3	3	7
Diabetes	29	—	—	1	—	—	—	1	2	4	7	14
Vascular lesions of nervous system	600	—	1	—	1	1	1	2	16	54	137	387
Coronary disease, angina	716	—	—	—	—	—	1	15	56	132	224	288
Hypertension with heart disease	53	—	—	—	—	—	—	2	5	5	15	26
Other heart disease	420	—	1	—	—	1	1	5	9	25	71	307
Other circulatory disease	170	—	—	—	1	1	—	6	3	22	39	98
Influenza	3	—	—	—	—	—	—	—	—	1	2	—
Pneumonia	195	3	11	2	4	1	1	2	3	12	24	132
Bronchitis	142	1	—	1	1	—	—	—	3	24	46	66
Other diseases of respiratory system	25	—	—	1	—	1	—	1	2	4	4	12
Ulcer of stomach and duodenum	19	—	—	—	—	—	—	—	2	3	8	6
Gastritis, enteritis and diarrhoea	20	2	3	1	—	—	1	2	2	1	2	6
Nephritis and nephrosis	19	—	—	—	1	—	—	2	5	4	4	3
Hyperplasia of prostate	13	—	—	—	—	—	—	—	—	1	2	10
Pregnancy, childbirth, abortion	2	—	—	—	—	1	1	—	—	—	—	—
Congenital malformations	50	22	13	4	2	3	1	—	1	2	2	—
Other defined and ill-defined diseases	343	69	3	6	5	4	6	15	21	30	45	139
Motor vehicle accidents	86	—	1	3	1	21	8	7	10	18	7	10
All other accidents	82	1	11	4	3	6	6	5	2	4	8	32
Suicide	37	—	—	—	—	4	3	3	8	14	3	2
Homicide and operations of war	1	—	—	—	—	1	—	—	—	—	—	—
All causes	3,843	98	45	30	24	49	47	111	238	585	864	1,752

TABLE 3B—CAUSES OF, AND AGES AT, DEATH, 1965

Causes of Death in County, 1965	Net Deaths in Age Groups of "Residents", whether occurring within or without the County											
	Age Groups											
	All Ages	Under 4 weeks	4 weeks under 1 year	1—	5—	15—	25—	35—	45—	55—	65—	75 and over
Tuberculosis, respiratory	18	—	—	—	—	—	—	1	4	3	8	2
Tuberculosis, other	—	—	—	—	—	—	—	—	—	—	—	—
Syphilitic disease	5	—	—	—	—	—	—	—	1	—	3	1
Diphtheria	—	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	—	—	—	—	—	—	—	—	—	—	—	—
Meningococcal infections	—	—	—	—	—	—	—	—	—	—	—	—
Acute poliomyelitis	—	—	—	—	—	—	—	—	—	—	—	—
Measles	1	—	—	—	—	1	—	—	—	—	—	—
Other infective and parasitic diseases	5	—	—	—	1	—	1	—	1	1	—	1
Malignant neoplasm, stomach	83	—	—	—	—	—	1	2	7	17	29	27
Malignant neoplasm, lung, bronchus	201	—	—	—	—	—	—	8	23	68	68	34
Malignant neoplasm, breast	70	—	—	—	—	—	—	7	13	17	20	13
Malignant neoplasm, uterus	28	—	—	—	—	—	—	2	1	8	8	9
Other malignant and lymphatic neoplasms	389	—	2	1	5	4	10	13	30	90	95	139
Leukaemia, aleukaemia	25	—	—	2	1	2	1	1	5	2	5	6
Diabetes	35	—	—	1	—	—	2	1	1	2	9	19
Vascular lesions of nervous system	584	—	1	—	—	—	4	4	19	52	120	384
Coronary disease, angina	803	—	—	—	—	—	1	22	45	153	220	362
Hypertension with heart disease	59	—	—	—	—	—	1	—	2	7	15	34
Other heart disease	431	—	—	1	—	1	3	5	11	22	74	314
Other circulatory disease	160	—	—	—	—	1	1	5	3	24	42	84
Influenza	5	—	—	—	—	—	—	—	—	—	3	2
Pneumonia	218	4	9	4	1	—	—	2	1	12	32	153
Bronchitis	158	—	1	2	—	1	—	1	10	24	56	63
Other diseases of respiratory system	31	—	1	1	—	—	—	2	2	5	9	11
Ulcer of stomach and duodenum	25	—	—	—	—	—	—	—	1	4	5	15
Gastritis, enteritis and diarrhoea	19	—	1	1	—	—	—	1	1	2	5	8
Nephritis and nephrosis	20	—	—	—	1	—	1	3	—	—	8	7
Hyperplasia of prostate	13	—	—	—	—	—	—	—	—	—	3	10
Pregnancy, childbirth, abortion	1	—	—	—	—	—	—	1	—	—	—	—
Congenital malformations	44	17	10	4	2	—	—	1	3	1	4	2
Other defined and ill-defined diseases	380	72	4	9	6	11	9	9	22	44	49	145
Motor vehicle accidents	73	—	—	2	5	15	11	4	5	13	13	5
All other accidents	91	2	4	3	2	6	10	7	8	5	11	33
Suicide	38	—	—	—	—	4	3	6	9	9	5	2
Homicide and operations of war	2	—	—	—	—	—	1	—	1	—	—	—
All causes	4,015	95	33	31	24	46	60	108	229	585	919	1,885

TABLE 4A—NOTIFICATIONS OF INFECTIOUS DISEASES, 1964

Diseases Notified	Cases Notified in Urban Districts								Cases Notified in Rural Districts											
	Abingdon Borough	Maidenhead Borough	Newbury Borough	New Windsor Borough	Wallingford Borough	Wantage Urban	Wokingham Borough	Total Urban Districts	Abingdon	Bradfield	Cookham	Easthampstead	Faringdon	Hungerford	Newbury	Wallingford	Wantage	Windsor	Wokingham	Total Rural Districts	Total County
Diphtheria	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	3	7	—	1	—	—	—	11	—	11	1	46	2	—	—	10	—	3	2	75	86
Encephalitis, acute (infective)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis, acute (post-infectious)	—	—	1	—	—	—	—	1	—	1	—	—	—	—	—	—	—	—	—	1	2
Erysipelas	2	—	—	2	—	—	—	4	1	1	—	6	—	—	—	—	1	1	2	12	16
Food poisoning	—	1	—	—	—	—	1	2	—	1	1	5	—	—	—	—	—	—	2	9	11
Malaria	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	2	2
Measles	78	178	6	102	12	19	96	491	159	119	96	304	18	1	5	6	49	35	406	1,198	1,689
Meningococcal infection	—	1	—	—	—	—	—	1	—	—	—	—	1	—	—	2	—	—	—	3	4
Ophthalmia neonatorum	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	1
Paratyphoid fever	1	—	1	1	—	—	—	3	—	—	1	—	—	—	—	—	—	—	—	1	4
Pneumonia, acute (primary or influenzal)	9	—	2	1	—	1	—	13	5	8	3	3	—	1	2	2	1	—	7	32	45
Poliomyelitis, acute (paralytic)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Poliomyelitis, acute (non-paralytic)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal pyrexia	2	1	—	—	—	—	6	9	—	—	—	5	—	—	—	—	—	—	4	9	18
Scarlet fever	—	2	—	1	—	1	10	14	3	2	1	12	6	—	1	2	10	6	29	72	86
Smallpox	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Tuberculosis, respiratory	7	15	4	4	2	9	4	45	16	8	2	10	5	2	9	7	8	5	20	92	137
Tuberculosis, meninges and central nervous system	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Tuberculosis, other forms	—	2	2	1	—	—	—	5	4	—	—	—	—	—	—	2	2	—	3	11	16
Typhoid fever	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	1	1
Whooping cough	27	5	21	—	—	4	18	75	23	39	16	72	3	28	31	15	11	8	100	346	421

TABLE 4B—NOTIFICATIONS OF INFECTIOUS DISEASES, 1965

Diseases Notified	Cases Notified in Urban Districts								Cases Notified in Rural Districts											
	Abingdon Borough	Maidenhead Borough	Newbury Borough	New Windsor Borough	Wallingford Borough	Wantage Urban	Wokingham Borough	Total Urban Districts	Abingdon	Bradfield	Cookham	Easthampstead	Faringdon	Hungerford	Newbury	Wallingford	Wantage	Windsor	Wokingham	Total Rural Districts	Total County
Diphtheria	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	3	37	17	—	—	1	55	113	3	22	30	82	8	—	1	70	3	7	20	246	359
Encephalitis, acute (infective)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis, acute (post-infectious)	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	1	1
Erysipelas	1	—	—	6	—	—	—	7	—	—	1	3	—	—	1	—	—	—	3	8	15
Food poisoning	1	5	—	6	—	—	3	15	—	2	2	7	—	—	1	1	—	—	5	18	33
Malaria	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Measles	278	405	337	247	198	79	468	2,012	430	581	224	1,081	178	42	474	244	248	310	987	4,799	6,811
Meningococcal infection	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	1	2	2
Ophthalmia neonatorum	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid fever	1	1	—	—	—	—	—	2	—	—	1	—	—	—	—	—	2	—	—	3	5
Pneumonia, acute (primary or influenzal)	—	1	1	6	—	—	—	8	5	5	2	5	—	2	2	—	—	1	8	30	38
Poliomyelitis, acute (paralytic)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Poliomyelitis, acute (non-paralytic)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal pyrexia	1	1	—	—	1	—	2	5	2	—	—	2	—	—	—	1	—	—	1	6	11
Scarlet fever	10	4	—	9	—	1	8	32	6	6	9	43	2	2	1	—	4	4	27	104	136
Smallpox	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Tuberculosis, respiratory	5	21	6	6	1	—	3	42	8	11	7	5	2	1	5	7	3	4	15	68	110
Tuberculosis, meninges and central nervous system	—	—	—	—	—	—	—	—	1	—	—	—	—	1	—	—	—	—	—	2	2
Tuberculosis, other forms	4	1	2	—	—	—	1	8	—	—	1	—	—	—	5	1	2	1	—	10	18
Typhoid fever	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	2	2
Whooping cough	6	16	10	5	—	—	—	37	—	6	25	38	—	1	21	—	—	1	31	123	160

TABLE 5A—PATIENTS UNDER L.H.A. CARE (31st DECEMBER,1964)

Category Age	Mentally Ill		Psycopath		Subnormal		Severely Subnormal		Total		Grand Total
	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	
Attending day training centre ..	—	3	—	—	—	13	99	59	99	75	174
Awaiting entry thereto	—	—	—	—	—	1	19	20	19	21	40
Attending residential training centre..	—	—	—	—	—	—	—	2	—	2	2
Awaiting entry thereto	—	—	—	—	—	—	—	—	—	—	—
Receiving home training	—	—	—	—	—	8	3	33	3	41	44
Awaiting home training	—	—	—	—	—	—	—	—	—	—	—
Resident in L.A. home-hostel ..	—	—	—	—	—	—	—	—	—	—	—
Awaiting residence thereto	—	—	—	—	—	—	—	—	—	—	—
Resident at L.A. expense											
In other homes-hostels	—	4	—	—	—	—	1	1	.1	5	6
In private households	—	—	—	—	—	—	—	—	—	—	—
Receiving home visits (not including above)	—	323	—	4	—	323	22	138	22	788	810
Total number	—	330	—	4	—	345	144	253	144	932	1,076

TABLE 5B—PATIENTS UNDER L.H.A. CARE (31ST DECEMBER, 1965)

Category Age	Mentally Ill Under 16	Mentally Ill 16+	Psycopath Under 16	Psycopath 16+	Subnormal Under 16	Subnormal 16+	Severely Subnormal Under 16	Severely Subnormal 16+	Total Under 16	Total 16+	Grand Total
Attending day training centre ..	—	—	—	—	—	—	134	99	134	99	233
Awaiting entry thereto	—	—	—	—	—	—	24	8	24	8	32
Attending residential training centre..	—	1	—	—	—	—	—	3	—	4	4
Awaiting entry thereto	—	—	—	—	—	—	—	—	—	—	—
Receiving home training	—	—	—	—	7	—	—	35	7	35	42
Awaiting home training	—	—	—	—	—	—	—	—	—	—	—
Resident in L.A. home-hostel ..	—	4	—	—	—	—	—	—	—	4	4
Awaiting residence thereto	—	—	—	—	—	—	—	—	—	—	—
Resident at L.A. expense											
In other homes-hostels	—	6	—	—	—	—	1	—	1	6	7
In private households	—	—	—	—	—	—	—	—	—	—	—
Receiving home visits (not including above)	1	136	—	11	—	263	25	114	26	524	550
Total number	1	147	—	11	7	263	184	259	192	680	872

TABLE 6A—PATIENTS AWAITING ADMISSION TO HOSPITAL (31ST DECEMBER, 1964)

PATIENTS ADMITTED FOR TEMPORARY RESIDENTIAL CARE DURING 1964

Category	Mentally Ill		Psycopath		Subnormal		Severely Subnormal		Total		Grand Total
Age	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	
Awaiting admission to hospital											
(a) Urgent admission	—	—	—	—	—	1	21	5	21	6	27
(b) Non-urgent admission ..	—	—	—	—	—	—	3	4	3	4	7
(c) Total	—	—	—	—	—	1	24	9	24	10	34
Admitted for temporary care											
(a) To N.H.S. Hospitals ..	—	—	—	—	—	4	16	4	16	8	24
(b) To L.A. Accommodation ..	—	—	—	—	—	—	—	—	—	—	—
(c) Elsewhere	—	—	—	—	—	—	1	—	1	—	1
(d) Total	—	—	—	—	—	4	17	4	17	8	25

TABLE 6B—PATIENTS AWAITING ADMISSION TO HOSPITAL (31ST DECEMBER, 1965)

PATIENTS ADMITTED FOR TEMPORARY RESIDENTIAL CARE DURING 1965

Category	Mentally Ill		Psycopath		Subnormal		Severely Subnormal		Total		Grand Total
Age	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	Under 16	16+	
Awaiting admission to hospital											
(a) Urgent admission	—	—	—	—	—	2	33	4	33	6	39
(b) Non-urgent admission ..	—	—	—	—	—	—	7	5	7	5	12
(c) Total	—	—	—	—	—	2	40	9	40	11	51
Admitted for temporary care											
(a) To N.H.S. Hospitals ..	—	—	—	—	—	1	38	6	38	7	45
(b) To L.A. Accommodation ..	—	—	—	—	—	—	—	—	—	—	—
(c) Elsewhere	—	—	—	—	—	—	—	—	—	—	—
(d) Total	—	—	—	—	—	1	38	6	38	7	45

TABLE 7A—AMBULANCE SERVICE STATISTICS 1964

Station	Total Journeys	Patients	Accidents	Maternity	Illness (Urgent)	Illness (Not urgent)	Other Journeys S.	Other Journeys D.	Other Journeys A.	Total Mileage
Abingdon	4,174	10,417	396	193	707	9,121	27	22	49	76,605
Ascot	376	405	60	33	153	159	2	1	12	6,220
Bracknell	6,778	10,589	763	228	830	8,768	54	321	61	94,352
Didcot..	4,768	14,793	169	214	478	13,932	41	95	55	118,021
Faringdon	1,577	4,993	120	49	110	4,714	12	9	10	45,576
Hungerford	357	627	44	12	39	532	23	43	3	6,786
Lambourn	155	173	48	25	61	39	1	1	3	6,132
Maidenhead	7,985	9,989	577	299	1,047	8,066	77	57	185	62,740
Maidenhead (Isolation Hospital) ..	225	235	—	—	7	228	—	—	—	2,523
Newbury	6,623	12,983	476	277	708	11,522	47	60	69	120,746
Wallingford	12	13	—	2	7	4	—	—	1	1,554
Wantage	1,824	5,963	112	74	194	5,583	11	39	14	49,076
Windsor	5,296	8,130	285	330	775	6,740	51	20	257	47,749
Wokingham	2,561	3,628	345	283	351	2,649	111	—	42	38,621
Totals	42,711	82,938	3,395	2,019	5,467	72,057	457	668	761	676,701

TABLE 7B—AMBULANCE SERVICE STATISTICS 1965

Station	Total Journeys	Patients	Accidents	Maternity	Illness (Urgent)	Illness (Not urgent)	Other Journeys S.	Other Journeys D.	Other Journeys A.	Total Mileage
Abingdon	4,240	11,346	434	179	638	10,292	25	10	55	89,152
Ascot	173	191	19	14	71	87	—	—	—	2,932
Bracknell	7,708	14,025	652	257	1,003	12,113	63	11	89	107,935
Didcot..	4,540	15,010	172	184	445	13,820	37	70	56	113,977
Faringdon	1,594	5,281	139	46	52	5,036	16	9	10	47,965
Hungerford	932	1,136	70	46	50	970	5	78	15	20,216
Lambourn	97	102	32	14	30	26	8	1	—	4,481
Maidenhead	8,408	11,154	436	234	1,020	9,437	79	49	150	70,390
Maidenhead Isolation Hospital ..	25	25	—	—	—	25	1	—	—	412
Newbury	6,780	13,719	589	291	578	12,261	29	23	101	130,160
Wantage	1,945	6,554	94	54	165	6,241	8	46	6	53,948
Windsor	5,339	8,890	260	264	771	7,605	34	6	331	54,150
Wokingham	3,029	5,119	276	270	374	4,199	106	3	32	46,154
Totals	44,801	103,547	3,173	1,863	5,197	84,112	411	306	845	741,872

APPENDIX C

STAFF OF THE HEALTH DEPARTMENT
(*As at 31st December, 1965*)

County Medical Officer of Health and Principal School Medical Officer:
D. E. CULLINGTON, M.A., M.B., B.CHIR., D.P.H., D.C.H.

Deputy County Medical Officer of Health and Deputy Principal School Medical Officer:
F. T. HUNT, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.I.H.

Senior Medical Officer:
P. H. CIMA, M.B., B.S., M.R.C.S., L.R.C.P.

District Medical Officers of Health and School Medical Officers:
E. BRITAIN, M.B., B.S., D.P.H.
F. R. HOWELL, M.B., CH.B., D.P.H.
R. HANDY, M.B., B.S., D.P.H.
R. M. LASLETT, CH.B., M.R.C.S., L.R.C.P., D.P.H.
S. J. MCCLATCHEY, M.B., B.CH., B.A.O., D.P.H.
I. W. MACKICHAN, O.B.E., M.B., B.CH., D.T.M. and H., D.P.H.
N. C. PARFIT, M.A., B.M., B.CH., D.P.H., D.T.M.

Medical Officers and School Medical Officers:
J. E. B. BLACK, L.R.C.P.I., L.R.C.S.I., L.M. (Part-time)
M. O'DONNELL, M.B., B.CH., B.A.O.
D. L. V. FRASER, M.R.C.P., L.R.C.P., D.A.
J. G. HARCOURT-NORRIS, M.R.C.S., L.R.C.P.
J. MCGREGOR EXLEY, M.B., CH.B., M.C.S.P.
A. J. JENKINS, M.D., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H.
J. P. LAWSON, M.B., CH.B.
E. H. C. STEWART, L.R.C.P., L.R.C.S.
A. M. WELLS-FURBY, M.A., B.M., B.CH., D.R.C.O.G.
V. A. WILKINSON, M.B., CH.B., D.P.M. (Part-time)

Chest Physicians (on staff of Regional Hospital Boards)
F. RIDEHALGH, M.D., M.A., M.B., B.CHIR., F.R.C.P., M.R.C.S., L.R.C.P.
G. SHAW, M.A., M.R.C.S., L.R.C.P.
B. THOMPSON, M.D., M.A., M.B., B.CHIR.

DENTAL SERVICE
Senior Dental Officer and Principal School Dental Officer:
O. JACOB, L.D.S., R.C.S.

Dental Officers:
P. H. CRAMPTON, L.D.S., R.C.S.
MRS. A. E. BRIGGS, L.D.S.
R. LOVEWELL, L.D.S., R.C.S.
C. A. PANK, L.D.S., R.C.S.
C. F. S. BROOKS, L.D.S., R.C.S. (Part-time)
D. M. HEWETT, L.D.S., R.C.S. (Part-time)
MRS. R. ROSENSTRAUCH, L.D.S. (Part-time)

Dental Auxiliaries:
MRS. A. MORSE
MISS L. WAKELING

NURSING, MIDWIFERY AND HEALTH VISITING

County Nursing Officer:

Miss A. M. Lamb, S.R.N., S.C.M., H.V. Cert., M.T.D., Q.N.S.

Deputy County Nursing Officer:

Miss M. E. Lindars, S.R.N., S.C.M., H.V. Cert., Q.N.S.

Area Nursing Officers:

Miss I. Galer, S.R.N., S.C.M., H.V. Cert., Q.N.S.
Mrs. M. Gallagher, S.R.N., S.C.M., H.V. Cert., Q.N.S.
Miss U. J. Haslam, S.R.N., S.C.M., H.V. Cert., Q.N.S.
Miss J. McTrusty, S.R.N., S.C.M., H.V. Cert., Q.N.S.
Miss A. Wilson, S.R.N., S.C.M., H.V. Cert., Q.N.S.
Miss S. P. C. Wright-Warren, S.R.N., S.C.M., H.V., Q.N.S.

Health Visitors	61
Health Visitors (Geriatric)	2
Health Visitor/Home Nurses	3
Health Visitor/Midwives	7
Health Visitor/Midwife/Home Nurses	31
Home Nurses	71
Home Nurse/Midwives	23
Midwives	32
Part-time Health Visitors	7
Part-time Home Nurses	24

MEDICAL SOCIAL WORKERS

Principal:

Miss A. Reidy, B.A. (Admin.) A.M.I.A. (Appointed 1.9.65)
Miss D. E. Penny, B.A.
Miss R. A. Bridge (Part-time)
Miss M. C. Brinton (Part-time)

MENTAL HEALTH SERVICE

Psychiatric Social Workers (Joint Appointments):

M. G. Picardie, B.A., Hons. D.A.S.S., A.A.P.S.W. (with Reading H.M.C.)
Miss M. C. Staton, S.R.N., S.C.M., A.A.P.S.W. (with St. Birinus H.M.C.)
Miss M. P. Chowdhury, B.Sc. (with East Berks Child Guidance)

Senior Mental Welfare/Welfare Officers:

J. G. Hathaway
G. L. Nicholls
S. J. Norwood
W. J. Owen
E. C. Crowe
F. W. Stratton
Mrs. P. M. Dickson

Mental Welfare/Welfare Officers:

B. C. Blandford
Mrs. N. Palmer
Mrs. J. W. Phillips
Miss J. H. Woodger

HOME TEACHERS

Miss J. Cooper, M.A.O.T.
Mrs. M. Larkin, M.A.O.T.
Miss B. Eavis, M.A.O.T.

COUNTY AMBULANCE SERVICE

County Ambulance Officer:

L. C. J. Harlow, F.I.A.O., F.I.C.A.P.

SCHOOL HEALTH SERVICE

School Nurses:

Full time School Nurses	15
Part-time School Nurse	1
Health Visitor/School Nurses	12
(equivalent to one whole time school nurse)	
School Nursing Assistant	1

Speech Therapists:

Miss A. R. Rickard, L.C.S.T.
Miss A. R. Self, L.C.S.T.
Mrs. J. A. Billen, L.C.S.T. (Part-time)
Mrs. M. Stone, L.C.S.T. (Part-time)
Mrs. J. H. Wingfield, L.C.S.T. (Part-time)

Physiotherapist:

Mrs. M. Griffin (Part-time)

Orthoptist:

Mrs. H. Caiger Smith (Part-time)

BERKSHIRE CHILD GUIDANCE SERVICE

Psychiatrist:

Dr. M. Ella Ward, M.B.B.S., D.P.M. (Part-time)
Dr. Ruth C. Doniger, M.B.B.S., D.P.H., D.C.H., D.P.M. (Part-time)
Dr. N. C. Morton-Gore, M.D., L.A.H., D.P.M. (Part-time)

Educational Psychologists:

Mr. W. C. King, M.A., B.Sc.
Dr. A. Singer, Ph.D., Dip. Ed. Psych.
Mr. R. J. Jeffery, B.A.

Psychiatric Social Workers:

Mrs. D. Liddle, A.A.P.S.W.
Miss P. Trafford, A.A.P.S.W.
Miss M. P. Chowdhury, B.Sc. (Part-time)

Administrative and Clerical:

Administrative Officer:
R. C. Parkin

Chief Clerk:
A. D. Chandler

Section Clerks:

R. S. Holman	Personal Health Section
P. J. Smith	Property, Equipment and Transport Section
A. T. Whitbread	School Health Section

SCHOOL HEALTH SERVICE

Aims of the Service

The School Health Service is essentially a preventive health service for children at school. In order to be effective it must make provision for the assessment of the health of these school children and for the ascertainment and care of the handicapped child. At the same time it must be concerned with the promotion of health in schools and the securing of hygienic conditions in these buildings.

The main object of the routine medical inspection is to help in producing a healthy child who will be able to benefit fully from his education at school and to assist in providing the basis for a fit and happy adult life.

The care and medical supervision of the handicapped pupil is one of the more specialised parts of the work of the service and includes the early assessment of the handicap, regular review and reassessment and advice as to the correct educational placement of the child.

The theme of good health should run throughout the work and life of the school child. Although much of this work will fall to the lot of the school teacher, the school medical officer and the school nurse and health visitor can give the appropriate help, guidance and advice in the promotion of health.

School Population

	Number		*Children in Attendance*	
Type of School	*1964*	*1965*	*1964*	*1965*
Nursery	13	13	624	677
Primary	246	242	38,859	40,964
Secondary Grammar	16	17	7,730	8,222
Secondary Modern	34	35	17,225	17,717
Special Schools	3	4	356	410
Totals	312	311	64,794	67,990

MEDICAL INSPECTION OF SCHOOL CHILDREN

It is the duty of a local education authority to provide for the medical inspection, at appropriate intervals, of pupils in attendance at any school or county college maintained by them.

In Berkshire a periodic medical inspection is carried out:

(a) As soon as possible after first admission to maintained school. (entrants)
(b) In the last year at primary school. (intermediate)
(c) As soon as possible after obtaining the age of fourteen years. (leavers)

A special examination is one carried out at the special request of a parent, doctor, nurse, teacher or other person.

A re-inspection is an inspection arising out of one of the periodic medical inspections or out of a special inspection.

Number of pupils inspected at schools was as follows:—

	1964	*1965*
Entrants	7,879	7,763
Intermediates	6,237	5,550
Leavers	4,808	3,917
Other periodic inspections	1,819	1,955
Total	20,743	19,185
Number of re-inspections	3,348	5,332
Number of special inspections	2,771	1,360
Grand Total	26,862	25,877

PHYSICAL CONDITION

Once again the physical and nutritional state of the children in the county continues to be very satisfactory. Only 33 of the 20,743 children subjected to periodical medical inspection during 1964 were found to have an unsatisfactory general condition, (0·16% of the number examined), and in 1965, 36 children out of a total of 19,085 were found to have an unsatisfactory general condition (0·21%).

UNCLEANLINESS AND VERMINOUS CONDITIONS

School Nurses made 98,962 individual examinations during 1964, and only 295 children were found to be verminous. During 1965 the figures were 65,192 and 256 respectively.

Routine examinations at all secondary schools had been discontinued at the end of 1963 because the infestation was exceedingly low, and visits to these schools are now only made on request or when it was thought to be necessary. In September, 1964 the routine visits to inspect children's heads for vermin were similarly discontinued at the primary schools when inspections over the previous six terms had indicated a satisfactory state of cleanliness.

FACILITIES FOR MEDICAL INSPECTIONS

Reference was made in the 1963 report to the lack of medical inspection rooms in many of the primary schools. School medical officers and school nurses completed a questionnaire on the facilities provided for medical inspections at each of the schools they visited during the months of April, May and June, 1964.

120 primary schools were visited during these three months and only nine of the schools had medical inspection rooms. Of the 111 schools without these rooms the examinations were undertaken in the following accommodation:—

Secretary's room	37 schools	Canteen	5 schools
Staff room	24 schools	Kitchen	1 school
Class room	20 schools	Library	2 schools
Head Teacher's room	8 schools	Assembly Hall	4 schools
		Storage room	1 school

Rented premises were used nearby at six schools and a neighbouring school was used in three other cases.

During the same period of time 21 secondary schools were visited and medical inspection rooms were available for use at 18 of these schools.

Medical Inspection Rooms

Following this survey a review was made of the medical inspection rooms provided in the secondary schools and, after seeking the views and opinions of the medical and nursing staff who completed the questionnaires, the following conclusions were reached:—

A medical room is considered to be essential in every secondary school and desirable in all primary schools. The room should be situated in a quiet part of the building preferably on the ground floor. Providing there are facilities for vision testing elsewhere in a room or corridor at least 20 feet in length, the medical inspection room need not be large but should be at least eight feet wide by ten feet long and capable of accommodating four persons. The room should have good natural lighting and efficient artificial lighting. Suitable curtains should be provided at the windows if the room is overlooked. Whilst central heating is usually provided, electrical points should be available for temporary heating when required. There should be a non slip floor and a wash hand basin with hot and cold water. A notice "Medical Examination Room" should be affixed to the door.

The following furniture and equipment should be provided:—

Two tables	Examination couch with blankets
Four chairs	Examination screen
Pedal bin	First aid cabinet
Angle poise type lamp	Suitable floor mat or rug

Waiting space for parents is usually necessary when medical examinations are being undertaken in an adjacent room, which can be used as a changing room for children, and reduce congestion and delay in the medical inspection room.

It would appear that a suite of small rooms is indicated in all large secondary schools for use during medical inspections. At other times these rooms could be used by the school nurse, dentist, speech therapist, teacher of the deaf, educational psychologist and for special teaching purposes. One of the rooms could also be used as a "Sick Room" or "Rest Room."

In primary schools a small room should be available for medical inspections but this room would obviously be used for different purposes at other times.

VISION

Routine Vision Testing

The vision of all children is tested by the school nurse as a routine procedure at each periodic medical inspection. At school entry the "E" type test is usually employed.

Towards the end of 1964 the school nurses began to carry out additional vision sweep tests on eight year old children at junior schools and 12 year old children at secondary schools. 1,236 children at 36 primary schools were tested and 76 (6·1%) were found to have defective vision. At the same time 693 children at six secondary schools were tested and 21 (3%) were also found to have defective vision. During 1965 this procedure was extended so that 3,746 8 year old children were tested, when 272 (7·2%) were found to have defective vision and 1852 12 year old children were tested when 115 (6·2%) were found to have defective vision.

During 1965 a tele binocular vision screener was purchased in order to facilitate vision screening. The full value of this apparatus is yet to be determined but it would appear that it will prove extremely useful.

School Eye Clinics	*1964*	*1965*
Number of children examined or re-examined ..	3661	4206
Number of new cases referred	754	1077
Number of children provided with spectacles ..	1212	1393

The School Eye Clinics are located at 13 centres: clinics were held on 262 occasions in 1964 and 302 occasions in 1965.

The Regional Hospital Boards provide the medical staff at the clinics. An additional ophthalmic surgeon working in the Bracknell area and an increase in the number of sessions at the Newbury Clinic have resulted in a reduction in the long waiting lists at Reading, Bracknell and Newbury referred to in the 1963 report.

Orthoptic Treatment

Cases of squint are treated by orthoptists at special clinics which are held at Oxford, Newbury, Maidenhead, Reading and Windsor. The Orthoptist at Greenham House, Newbury, is employed on a part-time basis by the Education Authority

Four sessions a week are held at Greenham House for school children. 255 children were referred to the Orthoptists during 1964 and 135 received treatment.

In 1965 262 children were referred to the Orthoptists and 108 received treatment.

Colour Vision Testing

The colour vision of all children was tested at the intermediate periodic medical examination (ten years old) and the tests were carried out with Ishihara plates. It is considered that this age is early enough to prevent any child choosing a career to which a colour vision defect would be a bar. Surveys during 1964 have indicated that the number of boys found to have defective colour vision was slightly less than 7% whilst the percentage in respect of girls was almost 0·6%.

HEARING

During 1964–65 the hearing of all school entrants was tested as a routine measure by school medical officers or school nurses using standardised voice tests. As an additional aid to testing the Royal National Institute for the Deaf's picture cards devised by Michael Reed were introduced during 1964. Children with defective hearing would be kept under observation or referred for further investigation.

Voice tests are satisfactory if carefully used but pure tone audiometry is more suitable for hearing screening. In early 1964, only one pure tone audiometer was available in the department but during the course of the year, additional apparatus was obtained. In the Autumn four school nurses were trained by the Senior Teacher of the Deaf in the technique of audiometry, and a further four in the Spring of 1965. Audiometry in young children requires a good deal of experience in order to win the child's confidence, condition him to the test and observe his responses. To produce valid results several months of practice after initial training are necessary and an ability to handle children is essential. Audiometric work was of course additional to the existing duties of these eight school nurses and because of this and the small number of audiometers available, the development of an audiology service was somewhat hampered.

Nevertheless during 1965 a start was made in setting up a School Audiology Service to serve the whole County. In order to do this, nine half day School Audiology Clinics were set up and each clinic was staffed by a school medical officer, the Senior Teacher of the Deaf and one of the school nurses trained in audiometry. The two doctors engaged in this work attended the course on deaf children at Manchester University in the Spring of 1965.

These School Audiology Clinics undertook the fuller investigation of those school children found to have more severe hearing losses and of selected preschool children with suspected hearing loss or language disorders.

So far it has only been possible to carry out audiometric tests on children at the request of school medical officers, head teachers, parents and others, but it is hoped in the future to carry out audiometric sweep testing of all 6 year old children.

In the latter part of 1965 it became possible to arrange for the audiometric testing of all children examined owing to backwardness at school, and arrangements have been made to carry out tests on all children in schools for educationally subnormal children and in the West Mead School for physically handicapped pupils at Wokingham. Hearing tests were also arranged for selected children with speech defects and it is hoped in the future to test all children referred to the speech therapist.

During 1965 724 audiograms were completed and 138 attendances were made at School Audiology Clinics, resulting in 85 referrals to hospital consultants.

SPEECH

Speech Therapists

As in 1963, for the greater part of the year 1964 there were only two full time speech therapists in the County instead of four. However, towards the end of 1964, a third full time speech therapist was appointed to work in the Wallingford and Wantage area. Later it became possible to employ three more speech therapists on a sessional basis in the Reading, Newbury and Abingdon areas. At the end of 1964 there were the equivalent of $3\frac{4}{5}$ full time speech therapists on the staff. With the large waiting lists and continual increase in the school population, however, it was considered that six full time speech therapists, or their equivalent, would be required during 1965. In 1965 the establishment was increased to six, including a senior speech therapist, but so far it has not been possible to fill these vacancies.

Clinics

Regular speech therapy clinics were held both in schools and five clinic premises during the year. Unfortunately suitable facilities for undertaking this type of work are not available at all the clinics and schools, but when new clinics are planned and designed in the future due regard will be made to the requirements necessary in rooms used for speech therapy purposes.

Attendances

A total of 333 children made 3,848 attendances at clinics during 1964, and 115 new cases were accepted. 107 children were discharged and, at the end of 1964, there were 345 children receiving or awaiting treatment.

In 1965 a total of 432 children made 6,112 attendances at clinics, and 161 new cases were accepted. 99 children were discharged and, at the end of 1965, there were 357 children receiving or awaiting treatment.

Speech Defects

The number of new cases were classified as follows:—

	1964	*1965*		*1964*	*1965*
Dyslalia ..	74	115	Cleft Palate Speech	6	2
Stammer ..	11	12	Retarded Speech Development	6	7
Lateral Sigmatism	5	8	Dysphasia	1	3
Interdental Sigmatism	8	12	Dysphonia	4	4

As in previous years, more children were treated for dyslalia than any other defect. It is considered that children with articulatory defects should be referred to the speech therapist at an early age and certainly no later than the age of six years. At the present time, however, there are not enough clinics where preschool children can be treated and consequently most children are only referred for treatment after they have commenced school.

There has been a steady increase in the number of children receiving treatment over recent years and this is partly due to the increase in the school population and partly to the growing awareness of the value of the therapy. In order to try and overcome the long waiting lists, time has been allotted each week by the speech therapists in order to interview children recently referred for treatment. At this diagnostic interview it is possible to ascertain the urgency of the case and to discuss the management of the child with the parents. On a number of occasions, it has been found that, as a result of the advice and guidance given to the parents, actual treatment of the child at the clinic becomes unnecessary. The treatment of the stammerers sometimes proves to be lengthy and it has occasionally been necessary to alternate treatment with short periods of rest.

Facilities for Speech Therapy

Miss Rickard works in the areas of Maidenhead and Newbury and she reports:—

> "Facilities were good on the whole. The main problem was one of noise, and much difficulty was experienced as a result of the noisy surroundings in which speech clinics were held particularly in schools."

Miss Pateman reports:—

> "Since October 1964, clinics have been established at three centres in North Berkshire:— Wallingford, Didcot and Wantage. The clinics at Didcot and Wantage were held in schools. Although conditions at these three clinics were not ideal, nevertheless they were centrally placed."

Mrs. Wingfield, who works on a sessional basis in a school for educationally subnormal children in Abingdon reports:—

> "My case load consisted of seventeen children whose I.Q's ranged from approximately 38–80 and their ages from six to 12 years. The clinic premises consisted of one small room in the main building, which was used as a medical room and a classroom, so that there was a shortage of storage space for equipment, and frequent interruptions during therapy sessions, by people coming and going. The light and heating in the room were adequate, but there was not sufficient soundproofing of the room, and external noises tended to distract some of my patients, and spoil tape recordings, these latter difficulties, however, were unavoidable."

HANDICAPPED PUPILS

Certain children may be so handicapped by physical, mental or other conditions, that special arrangements become necessary for their education. Under the Handicapped Pupils and Special Schools Regulations 1959, ten categories of handicapped pupils are recognised.

Blind and Partially Sighted Pupils

One child was classified as a blind pupil in 1964 and five more were placed in this category in 1965.

The number of children ascertained as "partially sighted" was six in 1964 and three in 1965.

Delicate and Diabetic Pupils

Fourteen children were placed in this category in 1964 and 13 in 1965. Most of the children ascertained as delicate suffer from asthma, recurrent bronchitis, congenital heart defects or haemophilia.

Epileptic Pupils

Two children were ascertained as epileptic pupils requiring special education in 1964 and two in 1965.

Maladjusted Pupils

Twenty nine children were ascertained as maladjusted pupils in 1964 and 54 in 1965.

Physically Handicapped Pupils

Twenty children were ascertained as physically handicapped pupils in 1964 and 22 in 1965.

Deaf and Partially Hearing Pupils

Six pupils were ascertained as partially hearing in 1964 and in 1965, seven pupils were ascertained as deaf and four as partially hearing.

Educationally Subnormal Pupils

	1964	*1965*
Number of children examined by approved school medical officers	344	462
Number of these children ascertained as educationally subnormal pupils	253	247
Number recommended for special educational treatment at an ordinary school	95	126
Number recommended for education in special schools	158	121
Number recommended as being more suitable for education at a training school	41	30

The examination of these children occupies a considerable amount of a medical officer's time as an average period of three hours is allowed for each individual examination.

Placement of Children

The number of children receiving education in special schools and at home at the end of 1964 and 1965 was as follows:—

	At Special Schools Units or Hostels		*At Home*	
	1964	*1965*	*1964*	*1965*
Blind	12	11	—	—
Partially Sighted	16	16	1	1
Deaf	17	16	—	1
Partially Hearing	9	6	3	1
Epileptic	7	6	2	2
Maladjusted	56	106	13	9
Speech Defects	1	1	—	—
Physically Handicapped	61	61	11	12
Delicate and Diabetic	27	24	11	7
Educationally Subnormal	465	435	6	9
Mentally Subnormal	100	135	44	56

Ascertainment of Handicapped Children

	1964	*1965*
Number of children ascertained as handicapped pupils requiring special educational treatment	331	362
Number of children recommended for special schools	225	171

Suitability for Education

It has become increasingly apparent that the dividing line between E.S.N. children who can be educated in schools provided by the Education Authority and those considered more suitable for education at the training schools provided by the local Health Authority for mentally subnormal children is an artificial one. Training schools provided by the Health Committee are, in fact, another type of special school for handicapped children, and the children are another group of handicapped pupils.

In many quarters there has been a move to draw the provisions made for mentally subnormal children nearer to those made for the educationally subnormal and to do away with formal ascertainment under Section 57 of the Education Act, 1944. This procedure causes many parents a good deal of distress and makes the transfer of a child back into the educational system difficult.

It has been felt that it would be an advantage for a child who is best placed in a training school to be transferred there with the mutual agreement of the parents and Local Authority without any formal action. It was, therefore, agreed early in 1965 to adopt an informal procedure for those children found to be more suitable for education at training school, and there is no doubt that this has proved of great benefit to all concerned.

Home Tuition

Home tuition is only recommended for handicapped pupils when other methods of education are impracticable and it is usually regarded as a temporary measure. Children receiving home tuition are reviewed frequently and those children who receive tuition over any length of time are usually physically handicapped, delicate or severely maladjusted. Forty five children were recommended for home tuition during 1964 and 61 in 1965.

B.C.G. VACCINATION OF SCHOOL CHILDREN

During 1964 and 1965 B.C.G. vaccination was offered to children in the secondary schools (including a number of independent schools) who had reached the age of 13 years, as well as to children over this age who had not previously been vaccinated.

The following table gives the figures for both years:—

Children given Pre-vaccination Heaf test (Tuberculin test)		*No. found to be tuberculin negative and given B.C.G. vaccination*		*No. found to be tuberculin positive*	
1964	*1965*	*1964*	*1965*	*1964*	*1965*
4,862	4,671	4,392	4,068	470 (9·7%)	603 (12·9%)

Where necessary arrangements are made for those children found to be tuberculin positive to have a chest x-ray to exclude any possibility of active tuberculosis. As in the previous year, no new cases of tuberculosis were reported from this group.

Heaf tests six weeks after vaccination are not now carried out by many Authorities but these are still done in Berkshire as we are continuing to assist Dr. Neville Irvine in his research at the B.C.G. Control Centre at Oxford. During the two years 6588 conversion tests were carried out and of these 126 failed to give the positive reaction which indicates a successful vaccination. However, these cases are retested the following year when the majority give positive reactions and it is rarely necessary to revaccinate a child.

Employment of School Children

During 1964 in accordance with the Children and Young Persons Act 1933, and the County Council Bye-Laws, school medical officers issued 1,113 medical certificates in connection with the part-time employment of pupils. Two children were found to be temporarily unfit to be employed in this type of work.

In 1965 medical certificates were issued for 1046 children.

Medical Examination of Other Persons

353 teachers, entrants to training colleges and other educational staff were medically examined by school medical officers in 1964.

In 1965, 437 individuals were examined.

SCHOOL NURSING SERVICE

In 1964 school nursing was undertaken by the equivalent of 17 full time school nurses, and in 1965, the establishment was increased to 18. In the Borough of Windsor, this work was undertaken by six Health Visitors, devoting $\frac{1}{6}$ of their time to these duties, assisted by a part time clinic nurse, while elsewhere in the County the work was carried out by full time school nurses.

It is recognised that many of the routine duties done by a school nurse can quite well be carried out by a suitably trained lay person working under the direction of a school nurse. Therefore, in 1965, an experiment was started in the Borough of Maidenhead whereby a lay person working only in term time assisted the six Health Visitors in carrying out the school nursing work

in the area. The Health Visitors devoted approximately $\frac{1}{12}$ of their time to school nursing duties and the lay assistant worked under their supervision and direction.

The nurses have continued to visit schools to carry out routine and special cleanliness inspections, vision tests, hearing tests and to attend routine medical inspections. Home visits were made either as special visits or as follow up work in connection with defects discovered at medical inspections. Visits were also made to the homes of a number of handicapped children.

During 1964 the routine visits made to primary schools every term for the purpose of "head inspections" were discontinued at schools where previous visits had indicated a satisfactory state of cleanliness. It is considered that more economic use should be made of school nurses' time in order that they can have more opportunity to make better contact with teachers to discuss health problems and to have more time to devote to the promotion of health in the schools.

As has already been mentioned under the sections dealing with "Hearing", eight school nurses have been trained to undertake audiometric testing in addition to their other duties.

Routine School Visits

Mrs. Rodgers, school nurse in the Didcot area, reports:— "Routine visits carried out by the school nurse are considered to be of great value in both primary and secondary schools. The form they take covers a very wide scope and varies according to the type of school visited but all with the same object in view—namely to maintain the healthy standards among the children and to give advice on the promotion of health. During the visit each child is observed in order to see that there is no abnormality in walking, that there are no defects of the eyes, speech and hearing, and that they appear neither underweight or overweight. Any defects are noted for future attention.

There are other factors which the school nurse, head teacher and staff discuss together. The school nurse is often asked to advise on such matters as hair styles and types of shoes worn by the pupils. The teaching staff bring to the notice of the nurse anything they have observed which may have some bearing on the physical or mental development of the child. Where any defects are suspected the child's home is visited in order to ascertain whether the parents are aware of these defects and whether any action is being taken. The relationship between teaching staff and nurse is excellent and we all work together for the benefit of the child".

The Changing Pattern

Miss Wilks reports:—

"The character of the work of school nurses obviously has to change in response to necessity and demand.

In the past, a large percentage of the work consisted of routine hygiene inspections, visiting the schools at least once a term for this purpose.

At the present time, hygiene inspections have been modified to those of necessity only. Foot inspections for verrucas and those for impetigo seem to have become more prominent of late. We help the doctor at school medical inspections and B.C.G. vaccination clinics. We also do a lot of home visiting in connection with the health of the school children. Added to this, we now do annual vision sweep tests on all children aged eight and twelve years, hearing tests with an audiometer in schools, and attend audiometric clinics and eye clinics. We also give occasional talks in schools, and speak at meetings of the Parent Teachers' Association.

What of the future? One would like to think that hygiene inspections

as such were no longer necessary, although in some areas, head infestation is still a real problem, and it's present overall reduction is largely due to the inspections and preventive work done in the past. One would also like to feel that sweep hearing testing is carried out on all children.

Our work is varied and interesting. Some of it's value lies in the fact that we are a liaison between teachers and parents, thereby presenting a more complete picture of the child's life at school and at home. We are also in close contact with the Health Visitors, who, of course, knew the children and their family life, prior to starting school. This is a great help in sorting out some of the problems in the most satisfactory way".

SCHOOL MEDICAL OFFICERS

In January, 1964, all the school medical officers in the county met together in order to discuss items of interest relating to the health of the school child. As this meeting proved so successful arrangements have now been made for similar meetings to be held two or three times each year.

Following discussions at the two meetings held during 1964 it was agreed that the routine weighing and measuring of every child at routine medical examinations were no longer necessary. Other points discussed have resulted in the introduction of a medical questionnaire for parents to complete before their children are medically examined, visits to schools once a term by the school medical officer whenever this is acceptable to the school, and more frequent vision testing and colour vision testing of boys and girls at the age of 10 years.

Much interest was shown in the handicapped school leaver and a new form has now been introduced which, when completed by the medical officer, provides much more information to the Youth Employment Officers than that on the existing Forms Y.9 and Y.10.

Medical officers have commented on the footwear of school children from time to time and reports have indicated the high proportion of badly fitting and poorly designed shoes. However, it is appreciated that such shoes may not necessarily be the cause of foot defects but probably only tend to make the deformities worse. Discussions between medical officers have indicated that there is still a need for much more information on the harmful effect of shoes on feet.

Role of School Medical Officer

A doctor working in the school health service needs to have a considerable knowledge of child development, and a basic understanding of the emotional and behaviour difficulties of children. At the same time he must be readily acquainted with the medical aspects of the learning difficulties shown by some school children. Handicapped children will occupy a certain amount of his time and a thorough understanding of the abilities and needs of the handicapped child is essential before suitable advice can be given on the placement of such children in the educational system. The promotion of health is another of the medical officer's functions and a knowledge of the techniques of health education is a further requirement that is necessary in order to fulfil his full role.

Health Promotion

The medical examinations undertaken by the school medical officer not only serve to discover defects and disorders requiring treatment, but also will detect the earliest signs of ill health and early deviation from the normal. Health supervision in schools must be comprehensive and, for this reason,

it is necessary for the doctor to be fully acquainted with the school children, the school teachers and the school environment.

Routine Medical Examinations

In the past the school medical officer's greatest contribution has been through the routine or periodic medical examination. There was obvious value in examining all the children at regular intervals of time in order that defects could be discovered and treatment arranged. In the future, however, whilst full medical examination of school entrants will still be necessary, some modification of the other routine medical examinations may be desirable in order to avoid the medical examination of large numbers of healthy children and to allow a greater amount of time to be spent on the examination and assessment of selected children. At the same time it must be remembered that the routine examinations do enable the parent and doctor to meet in the school. Several of the school medical officers have indicated the value of such meetings and, in no other way, do parents have a regular opportunity to discuss with the doctor questions and difficulties about their children's health and developmental progress. The Education Committee has authorised experiments with "selective" medical examinations.

DENTAL HEALTH REPORT
OF THE
CHIEF DENTAL OFFICER
FOR THE YEARS
1964/65

During 1964 we lost the services of Mr. Davies-Evans, the full-time dental officer in the Newbury area, who resigned owing to ill-health, and Mr. Kerley, a private practitioner at Hungerford, who treated the local school children under a special arrangement, retired from practice. I would like to wish Mr. Kerley every happiness in his retirement.

Mr. Monnechendam joined in a part-time capacity at Maidenhead and stayed till June 1965. Mrs. Griffin who replaced Mr. Davies-Evans in a part-time capacity at Newbury resigned in December 1965 owing to personal reasons.

Owing to these various changes we suffered a decrease of 1·6 in terms of full time dental officers during the period January 1964 and December 1965, but I hope we shall be able to make good this loss in the coming year.

Miss Elton, Dental Surgery Assistant, retired at the end of 1965 after many years service and I wish her every happiness in her retirement.

Our staff of Dental Auxiliaries has been increased to two by Miss L. Wakeling who joined the staff in September 1964, with a view to working in the Abingdon clinic. Unfortunately, there has been a hold up in the plans for the clinic, and this has made it difficult to give Miss Wakeling as much practical work as was hoped. A series of dental health talks have been and are being given by her in the Abingdon and Didcot primary and infant schools and to the Tesdale children. I am most grateful for the help and co-operation Miss Wakeling and I have received from the Heads and staff at these schools. Similarly in Bracknell and also in the Wokingham area Mrs. Morse, the other dental auxiliary has continued giving talks on dental health and again the help and co-operation of the Heads and their staff have been invaluable.

It is rather disappointing that those responsible for the Dental Auxiliary experiment seem to take so little interest in how the scheme is functioning and seeing the excellent work carried out by these girls, which is a credit to the training they have received at New Cross Hospital.

In November 1965 two assessors appointed by the General Dental Council came down to inspect some 50 children chosen by them from a list of children treated by the Dental Auxiliaries, and I am looking forward to hearing their comments, if any. In 1964, Mrs. Briggs, the Dental Officer at Windsor clinic carried out a comparative survey of a group of children living in a area which provided water containing at least 1 part per million of fluorine against a similar group where water supply was comparatively fluorine free.

While not assuming to be a scientific survey, it did confirm that where fluorine was in the water, the dental decay rate was less than in the fluorine free water area.

I am most grateful to Mrs. Briggs and Dr. McClatchey and the Borough Water Engineer for all their help and to the parents and schools involved for their co-operation.

The Mobile Dental Unit at Abingdon continues to fulfill a useful function but myself and the staff are looking forward to the day when we have a fixed clinic at Abingdon.

A course for training dental surgery assistants has been started by the College for Further Education, Woodley, and we have been able to co-operate by having some of the girls attend our clinics in order to see the practical side of the work.

In October 1964, Mr. Potter a dental officer of the Department of Education and Science visited us to carry out an inspection of the school dental service. A detailed survey of our clinics was made and he met a number of the Dental Officers. His report was most gratifying and helpful, and some recommendations were made in regard to equipment. I am happy to say most of the changes suggested were in fact already being put in hand.

One is still left with the problem of how to attract full time dental officers willing to make the service a career, and as I have said in previous reports, to get staff, one must have attractive modern clinics. I am hopeful that as the ambitious building programme for clinics is fulfilled, we shall have less difficulty in attracting new entrants. In December 1965, we were able to hold our first dental clinic in the new Abbey Mill House clinic, and I would like to express my thanks to the authority for the delightful new clinics provided, and I am sure they will be appreciated by both staff and patients. Arrangements are in hand for the dental consultant who treats patients at Borocourt Hospital to do dental inspections at the training schools, and to advise at the same time on which children he thinks should be treated at the Hospital dental clinic. This will be of great help and save having to refer children to the Dental Consultant at Borocourt for a preliminary inspection.

I would like to express my thanks to the professional and clerical staff, and to the Head Teachers and their staffs for all their help and co-operation.

BERKSHIRE CHILD GUIDANCE SERVICE

ANNUAL REPORT

1.1.64–31.12.65

In Child Guidance work more than in any other branch of medicine, the child is studied as a whole person in relation to the family and community, and his or her difficulties are intensively investigated through the combined team work of Psychiatric Social Worker, Psychologist and Psychiatrist to discover and where possible remove or relieve the causes of stress. Work with the parents and family is an essential part of treatment and other case workers and teachers concerned with the child and family are brought into the investigation and treatment of the child as far as possible. The Clinic Staff feel that statistics such as numbers of clinic interviews give no idea and often give a misleading impression, of the extent of the work done in the Child Guidance Service. We have therefore reduced the statistics for this report to a minimum and concentrated on reports from the different clinics on new developments and needs. There is increasing demand for the services of the Child Guidance Clinic in all areas and the pressure of work on the present establishment of staff is very heavy.

Clinic Headquarters in Reading

The Clinic at 27, Kidmore Road, Caversham was the Headquarters of the Berkshire Child Guidance Service until February 1966 when it was transferred to its present new premises at Abbey Mill House, Abbey Square, Reading. The removal from 27, Kidmore Road marks the ending of an epoch dating from 1943 when the house at 27, Kidmore Road, Caversham, was first taken over for the dual purpose of a joint Evacuation Hostel for difficult unbilletable evacuees and the Headquarters of the Child Guidance Clinic established in 1942. The new premises at Abbey Mill House provide a more central modern clinic in close contact with the School Medical Clinic on the same floor and the Children's Department Headquarters above. This we hope will lead to closer contact and co-operation between the services.

Dr. Doniger and the East Berkshire Clinic team had to give up their session in the Reading Clinic Headquarters in order to devote more time to the increasing work in Bracknell and East Berkshire. Dr. Ward and the Central Berkshire Clinic team took over new cases referred to the Reading Headquarters from Sonning, Woodley and Earley areas from 31.3.65.

EAST BERKSHIRE—1964

Bracknell New Town

A new clinic has been started in the Bracknell Health Centre one complete day on the first and third Wednesdays of the month beginning in May 1964. This one day has already proved to be totally inadequate for the needs of the area.

Personal changes

Mr. Picardie, our trainee social worker, left in September 1964 leaving a vacancy for a full time P.S.W. on this side of the county.

Mrs. Thurston, the clinic secretary, who had worked loyally for fourteen years, retired at the end of October and was replaced by Mrs. Buttrum.

EAST BERKSHIRE—1965

Personnel Changes

This year has marked great changes in this area. Mr. J. N. Hooker who worked in this clinic for 15 years as psychiatric social worker and later as senior psychiatric social worker, left at the end of March 1965 to take up research with International Social Services. The whole character of the clinic altered when he left. For six months the clinic had to struggle along without a social worker.

Appointment of Miss N. P. Chowdhury

The appointment of Miss Chowdhury, who started work with the clinic in October 1965 marks a new step towards co-ordinating the Community Mental Health Services in East Berkshire. Hers is a joint appointment with the Education Committee, working with the Child Guidance Clinic, and the Health Committee working in the community in close liaison with those hospitals in this area taking psychiatric cases. Her appointment has given special pleasure as she has previously worked for Berkshire Child Guidance Service.

Psychiatric Social Worker Establishment in East Berkshire

There is the establishment for two whole time psychiatric social workers. We are therefore understaffed by one and a half P.S.W's. We have been fortunate in having some help on a sessional basis averaging about one session a week.

South Lodge

This hostel which has been planned to be a continuation for Field House members requiring further stabilisation after leaving school, was opened on July 16th, 1965. One girl started work straight away from this date. In September, four girls were transferred from Field House making a total of five.

The staffing of the hostel from the time of opening till the end of the year has been on a skeleton basis with a matron in residence only. This has thrown an increasing load of work on Mr. and Mrs. Cochrane who are

responsible for the two hostels. Here again there is a happy working union between the Education and Health Committees.

Clerical Staff

Mrs. Stone commenced work as part time typist in the afternoons only on May 24th, 1965. She does not come in the school holidays. She is unable to give more time during the term owing to lack of space in the clinic.

ABINGDON CLINIC

There has been considerable expansion of the work in North Berkshire, with a growing volume of referrals to the Abingdon clinic, and generally a strengthening of links with community services and workers in many fields. This is an area with an entity of its own, now reflecting the further development of County services.

General practitioners have shown an increasing interest, and referrals from them have been the basis of the expansion of work. Other County departments have also referred to and conferred with members of the clinic team on many of their cases. The clinic case conferences have brought round the table general practitioners, head teachers, nursing officers and social workers from different backgrounds.

The educational psychologist has seen a number of children for educational therapy (including some of the hostel children). Certain other children with learning difficulties associated with some degree of brain damage have been helped by home teaching (under the supervision of the psychologist) plus part-time attendance at their primary schools. Some of these children are reaching secondary school age and their education is becoming a major problem. This type of child is too disturbing in an ordinary class and cannot benefit from education in a large secondary school. They do not fit into E.S.N. schools nor into special schools for maladjusted children. There is urgent need for a small day unit for maladjusted children, with a specially trained teacher who is interested in this type of child.

The social worker strength of the clinic has been usefully augmented by students from Liverpool and Newcastle universities who have worked under the supervision of the psychiatric social worker. Some of these were mature and experienced workers who, in the process of learning to increase their own skills, were able to work intensively on a few cases, and thus gave a service which formed a valuable component of the year's work.

Summerfield Hostel reopened in January 1964 under the new warden and matron, Mr. and Mrs. Roebuck, and by the end of the year had its full complement of twelve children. They have all settled in and there is a happy family atmosphere in the hostel.

Personnel changes.

Mrs. Trenaman was appointed as Clinic Secretary in succession to Mrs. Duckworth who resigned on 13.8.65. Mrs. Trenaman is a great asset to the smooth running of this busy clinic.

NEWBURY CLINIC

The clinic continues to have a steady stream of new cases with a short waiting-list. The number of children under regular treatment remains fairly constant.

Working conditions at the Newbury clinic have improved slightly in that the door between the rooms of the psychiatric social worker and the psychiatrist has now been made soundproof. This does not, of course, alter the fact that the P.S.W's room is far too small and still has no exit other than

through the psychologist's or the psychiatrist's rooms. Another disadvantage of the Newbury clinic is that there is no receptionist at Greenham House and members of the clinic team are continually interrupted by enquiries for other clinics, both on the telephone and in person.

Both because of the cramped and difficult working conditions at Greenham House and because of the transport difficulties for patients on Mondays (the only day we are able to hold our clinic in Newbury), it would be most helpful if we could have our own premises. We could then alter the clinic day to coincide with market-day when transport is considerably easier, and the P.S.W. and psychologist could use the premises on other days and save considerable time spent on travelling and expand the school psychological service.

Members of the team continue to give talks to Young Wives' Groups and P.T.A's, etc.

Personnel Changes

Dr. Morton-Gore, Consultant Psychiatrist at Borocourt Hospital was appointed by the Area Department of Psychiatry to take over the Child Guidance Clinic in Newbury from Dr. Ward on the 1st November 1965. Dr. Ward reluctantly had to give up her sessions in Newbury on cutting down her work from full-time to maximum part-time.

APPENDIX A

BERKSHIRE CHILD GUIDANCE SERVICE CLINICS 1965

Clinic	Sessions	Psychiatrist	Psychologist	Psychiatric Social Worker	Appointments Secretary
READING *Headquarters:* 27, Kidmore Road, Caversham. Moved February 1966 to:— Abbey Mill House, Abbey Square, Reading. *Tel.:* 56631	Open daily, patients seen by appointment	Dr. M. E. Ward	Mr. W. C. King	Miss P. Trafford Mrs. D. Liddle	Miss E. Evans
MAIDENHEAD *Headquarters:* EAST BERKSHIRE 3, Clare Road, Maidenhead. *Tel.:* 24408	Open daily, patients seen by appointment	Dr. C. R. Doniger	Mr. R. Jeffery	Miss N. Paul Chowdhury	Mrs. Buttrum
ABINGDON *Headquarters:* NORTH BERKSHIRE Faringdon Road, Abingdon. *Tel.:* 1935	Open daily, patients seen by appointment	Dr. M. E. Ward	Dr. A. Singer	Mrs. D. Liddle	Mrs. Trenaman
NEWBURY Greenham House, Newbury. *Tel.:* 737	Mondays a.m. p.m.	Dr. N. Morton-Gore	Mr. W. C. King	Miss P. Trafford	Miss E. Evans (from Reading Clinic)
BRACKNELL Health Centre, Bracknell. *Tel.:* 4411	Mondays a.m. p.m. Every 3rd Wed. in the month p.m.	Dr. C. R. Doniger	Mr. R. Jeffery	Miss N. Paul Chowdhury	Mrs. Buttrum (from Maidenhead Clinic)
FARINGDON Health Centre, Faringdon *Tel.:* 2119	Occasional sessions as required	Dr. M. E. Ward	Dr. A. Singer	Mrs. D. Liddle	Mrs. Trenaman (from Abingdon Clinic)

APPENDIX B

BERKSHIRE CHILD GUIDANCE SERVICE

STAFF 1964–1965

Psychiatrists
Dr. M. Ella Ward, M.B.B.S., D.P.M.
Dr. Ruth C. Doniger, M.B.B.S., D.P.H., D.C.H., D.P.M.
Dr. N. Morton-Gore, M.D. (Rome), L.A.H., D.P.M. (Appointed 1.11.65).

Educational Psychologists
Dr. A. Singer, Ph.D., Dip.Ed.Psych.
Mr. W. C. King, M.A., B.Sc., Dip.Psych.
Mr. R. J. Jeffery, B.A.

Psychiatric Social Workers
Mr. J. N. Hooker, B.Sc., A.A.P.S.W. (Senior P.S.W.) resigned 31.3.65.
Mrs. D. Liddle, A.A.P.S.W. (Senior P.S.W. from 1.11.65.)
Miss P. Trafford, A.A.P.S.W.
Mr. M. Picardie, B.A. (Trainee)—Resigned September 1964.
Miss N. Paul Chowdhury (Part-time)—Appointed October 1965.—A.A.P.S.W.

Secretarial Staff
Miss E. Evans, Clinic Secretary, Reading.
Mrs. Bowman (part-time) Reading.
Mrs. Harris (part-time) Reading.

Mrs. A. Thurston, Clinic Secretary, Maidenhead—Resigned 31.10.64.
Mrs. E. F. Buttrum, Clinic Secretary, Maidenhead—Appointed 1.11.64.
Mrs. Mouldey (part-time), Maidenhead.
Mrs. Stone (part-time), Maidenhead.

Mrs. M. Duckworth, Clinic Secretary, Abingdon, Resigned 13.8.65.
Mrs. H. Trenaman, Clinic Secretary, Abingdon—Appointed 4.10.65.

APPENDIX C

BERKSHIRE CHILD GUIDANCE HOSTELS

Place	Name	Warden and Matron	Number of Places	Sex and Age Range	Number of Children Treated during the Year	
					1964	*1965*
Wokingham	Field House	Mr. and Mrs. Cochrane	13	Senior Girls	13	16
	South Lodge (opened 16/7/65)	Mr. and Mrs. Cochrane	9	Senior Girls From Field House	—	5
Maidenhead	Green Field House	Mr. and Mrs. Prescott	15	Senior Boys	15	17
Abingdon	Summerfield	Mr. and Mrs. Roebuck	12	Junior Mixed	12	14

APPENDIX D

BERKSHIRE CHILD GUIDANCE SERVICE

	1964	*1965*
Number of new cases seen during the year	274	332
Total number of children attending the clinic during the year	526	585

STATISTICAL TABLES INDEX

APPENDIX ONE

STATISTICAL TABLES (SCHOOL HEALTH SERVICE)

PART I 1964

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

TABLE A.—PERIODIC MEDICAL INSPECTIONS

Age groups Inspected (By year of Birth) (1)	No. of Pupils Inspected (2)	Physical Condition of Pupils Inspected: Number Satisfactory (3)	Physical Condition of Pupils Inspected: Number Unsatisfactory (4)
1960 and later	391	391	—
1959	2,891	2,889	2
1958	3,443	3,438	5
1957	1,154	1,152	2
1956	721	721	—
1955	602	602	—
1954	2,406	2,403	3
1953	2,828	2,826	2
1952	1,003	997	6
1951	496	492	4
1950	1,183	1,179	4
1949 and earlier	3,625	3,620	5
TOTALS	20,743	20,710	33

TABLE B.—PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC MEDICAL INSPECTIONS 1964

Age Groups Inspected (By year of Birth)	For Defective Vision (Excluding Squint)	For any other conditions recorded in Part II A	Total Individual Pupils
1960 and later	13	62	64
1959	101	416	441
1958	174	586	649
1957	84	194	241
1956	42	113	39
1955	58	75	116
1954	205	320	460
1953	159	330	519
1952	119	118	216
1951	70	43	105
1950	129	126	129
1949 and earlier	449	288	675
TOTALS	1603	2671	3654

TABLE C.—OTHER INSPECTIONS

Number of Special Inspections	2,771
Number of Re-Inspections	3,348
TOTAL	6,119

TABLE D.—INFESTATION WITH VERMIN

(1) Total number of individual examinations of pupils in the schools by the school nurses or other authorised persons	98,962
(2) Total number of individual pupils found to be infested	295
(3) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	—
(4) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	—

PART II 1964

DEFECTS FOUND BY MEDICAL INSPECTION DURING THE YEAR

TABLE A.—PERIODIC INSPECTIONS

Code No.	Defect or Disease	Entrants 'T'	Entrants 'O'	Leavers 'T'	Leavers 'O'	Others 'T'	Others 'O'	Total 'T'	Total 'O'
4	Skin	99	107	107	26	120	74	326	207
5	Eyes (a) Vision	332	398	467	63	804	265	1603	726
	(b) Squint	149	68	24	7	83	34	256	109
	(c) Other	27	16	6	4	43	13	76	33
6	Ears (a) Hearing	158	375	11	41	49	122	218	538
	(b) Otitis Media	57	238	8	12	24	59	89	309
	(c) Other	8	42	4	1	14	11	26	54
7	Nose and Throat	229	576	22	27	79	91	330	694
8	Speech	65	77	7	6	39	48	111	131
9	Lymphatic Glands	6	111	—	8	2	26	8	145
10	Heart	18	167	4	19	21	78	43	264
11	Lungs	110	181	20	17	54	95	184	293
12	Development (a) Hernia	26	44	2	6	9	14	37	64
	(b) Other	29	162	27	26	78	148	134	336
13	Orthopaedic (a) Posture	5	59	31	20	38	72	74	151
	(b) Feet	165	129	26	21	84	84	275	234
	(c) Other	48	30	50	32	36	94	131	156
14	Nervous System (a) Epilepsy	15	18	3	—	13	14	31	32
	(b) Other	11	52	7	11	19	58	47	121
15	Psychological (a) Development	14	112	13	8	63	53	90	173
	(b) Stability	59	313	4	8	63	127	126	448
16	Abdomen	31	94	8	12	30	31	69	157
17	Other	47	57	26	18	104	71	177	146

'T'—means requiring treatment 'O'—means requiring observation

TABLE B.—SPECIAL INSPECTIONS

Defect Code No.	Defect or Disease	Requiring Treatment	Requiring Observation
4	Skin	58	34
5	Eyes (a) Vision	481	227
	(b) Squint	69	42
	(c) Other	8	10
6	Ears (a) Hearing	46	117
	(b) Otitis Media	7	36
	(c) Other	14	8
7	Nose and Throat	79	108
8	Speech	59	102
9	Lymphatic Glands	—	18
10	Heart	16	101
11	Lungs	41	77
12	Development (a) Hernia	4	12
	(b) Other	50	126
13	Orthopaedic (a) Posture	30	23
	(b) Feet	48	40
	(c) Other	30	47
14	Nervous System (a) Epilepsy	22	17
	(b) Other	8	33
15	Psychological (a) Development	66	47
	(b) Stability	47	121
16	Abdomen	21	31
17	Other	62	67

PART III 1964

TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

TABLE A.—EYE DISEASE, DEFECTIVE VISION AND SQUINT

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint ..	211
Errors of refraction (including squint)	3,966
TOTAL	4,177
Number of pupils for whom spectacles were prescribed ..	1,341

TABLE B.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	unknown
(b) for adenoids and chronic tonsilitis	
(c) for other nose and throat conditions	
Received other forms of treatment	67
TOTAL	67
Total number of pupils in schools who are known to have been provided with hearing aids—	
(a) in 1964	21
(b) in previous years	71

TABLE C.—ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases known to have been dealt with
(a) Pupils treated at clinics or out-patients departments ..	611
(b) Pupils treated at school for postural defects	94
TOTAL	705

TABLE D.—DISEASES OF THE SKIN
(excluding uncleanliness, for which see Table D part 1)

	Number of cases known to have been dealt with
Ringworm—(i) Scalp	—
(ii) Body	2
Scabies	7
Impetigo	63
Other skin diseases	100
TOTAL	172

TABLE E.—CHILD GUIDANCE TREATMENT

Pupils treated at Child Guidance clinics	526

TABLE F.—SPEECH THERAPY

Pupils treated by Speech Therapists	333

TABLE G.—OTHER TREATMENT GIVEN

(a) Pupils with minor ailments	944
(b) Pupils who received convalescent treatment under School Health Service arrangements	—
(c) Pupils who received B.C.G. vaccination	4,392
TOTAL	5,336

PART IV 1964

DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY

Attendances and Treatment		Totals
First visit	5,339	
Subsequent visit	11,298	
Total visits	16,637	
Additional courses of treatment commenced	*	
Fillings in permanent teeth	7,202	
Fillings in deciduous teeth	4,007	11,209
Permanent teeth filled	6,732	
Deciduous teeth filled	3,819	10,551
Permanent teeth extracted	950	
Deciduous teeth extracted	3,675	4,625
General anaesthetics	1,971	
Emergencies	*	
Number of pupils X-rayed	*	
Prophylaxis		
Teeth otherwise conserved	6,118	
Number of teeth root filled		
Inlays	—	
Crowns	—	
Courses of treatment completed	*	

Orthodontics	
Cases remaining from previous year	52
New cases commenced during year	46
Cases completed during year	25
Cases discontinued during year	4
No. of removable appliances fitted	42
No. of fixed appliances fitted	5
Pupils referred to Hospital Consultant	3

Prosthetics	
Pupils supplied with F.U. or F.L. (first time)	*
Pupils supplied with other dentures (first time)	17
Number of dentures supplied	17

Anaesthetics	
General Anaesthetics administered by Dental Officers	—

INSPECTIONS

(a) First inspection at school. Number of Pupils	29,464
(b) First inspection at clinic. Number of Pupils	461
Number of (a) and (b) found to require treatment	*
Number of (a) and (b) offered treatment	*
(c) Pupils re-inspected at school clinic	*
Number of (c) found to require treatment	*

SESSIONS

Sessions devoted to treatment	2,822
Sessions devoted to Inspection	256
Sessions devoted to Dental Health Education	*

* Figures not available

Appendix TWO

STATISTICAL TABLES (SCHOOL HEALTH SERVICE)

PART I 1965

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

TABLE A.—PERIODIC MEDICAL INSPECTIONS 1965

Age groups Inspected (By year of Birth) (1)	No. of Pupils Inspected (2)	Physical Condition of Pupils Inspected: Number Satisfactory (3)	Physical Condition of Pupils Inspected: Number Unsatisfactory (4)
1961 and later	297	295	2
1960	2,930	2,928	2
1959	3,497	3,492	5
1958	1,039	1,037	2
1957	786	781	5
1956	542	540	2
1955	2,629	2,625	4
1954	2,379	2,375	4
1953	722	721	1
1952	447	447	—
1951	1,029	1,025	4
1950 and earlier	2,788	2,783	5
Totals	19,085	19,049	36

TABLE B.—PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC MEDICAL INSPECTIONS 1965

Age Groups Inspected (By year of Birth)	For Defective Vision (Excluding Squint)	For any other conditions recorded in Part II A	Total Individual Pupils
1961 and later	9	55	62
1960	114	433	388
1959	211	660	746
1958	69	220	242
1957	77	150	168
1956	51	106	127
1955	230	422	505
1954	229	372	513
1953	86	107	180
1952	75	69	127
1951	136	153	242
1950 and earlier	318	215	584
TOTALS	1,605	2,962	3,884

TABLE C.—OTHER INSPECTIONS 1965

Number of Special Inspections	1,360
Number of Re-Inspections	5,332
TOTAL	6,692

TABLE D.—INFESTATION WITH VERMIN 1965

(1) Total number of individual examinations of pupils in the schools by the School Nurses or other authorised persons	65,192
(2) Total number of individual pupils found to be infested ..	256
(3) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	—
(4) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944) ..	—

PART II
DEFECTS FOUND BY MEDICAL INSPECTION DURING THE YEAR
TABLE A.—PERIODIC INSPECTIONS 1965

Code No.	Defect or Disease	Entrants 'T'	Entrants 'O'	Leavers 'T'	Leavers 'O'	Others 'T'	Others 'O'	Total 'T'	Total 'O'
4	Skin	111	51	86	45	148	64	345	160
5	Eyes (a) Vision ..	330	489	468	143	807	1	1605	633
	(b) Squint ..	153	82	19	6	72	24	244	112
	(c) Other ..	39	29	7	6	27	18	73	53
6	Ears (a) Hearing ..	218	423	28	26	137	162	383	611
	(b) Otitis Media	102	158	15	10	27	69	144	237
	(c) Other ..	23	37	6	2	13	9	42	48
7	Nose and Throat ..	292	729	52	61	131	195	475	985
8	Speech	90	314	14	20	51	76	155	410
9	Lymphatic Glands	10	152	3	5	5	30	18	187
10	Heart	12	155	11	25	16	83	39	263
11	Lungs	119	160	18	28	46	77	183	265
12	Development (a) Hernia ..	38	51	7	6	21	33	66	90
	(b) Other ..	41	196	22	32	72	159	135	387
13	Orthopaedic (a) Posture ..	16	72	23	33	39	106	78	211
	(b) Feet	113	181	45	31	101	105	259	317
	(c) Other ..	54	134	24	47	49	92	127	273
14	Nervous System (a) Epilepsy ..	7	15	6	6	9	10	22	31
	(b) Other ..	9	56	8	8	12	54	29	118
15	Psychological (a) Development	26	142	11	9	42	108	79	259
	(b) Stability ..	49	215	13	21	81	188	143	424
16	Abdomen	29	84	10	17	33	54	72	155
17	Other	128	56	39	13	140	54	307	123

'T'—means requiring treatment 'O'—means requiring observation

TABLE B.—SPECIAL INSPECTIONS 1965

Defect Code No.	Defect or Disease	Requiring Treatment	Requiring Observation
4	Skin	30	18
5	Eyes (a) Vision	369	199
	(b) Squint	43	17
	(c) Other	4	4
6	Ears (a) Hearing	29	117
	(b) Otitis Media	12	32
	(c) Other	3	4
7	Nose and Throat	38	82
8	Speech	42	55
9	Lymphatic Glands	3	7
10	Heart	8	98
11	Lungs	22	47
12	Development (a) Hernia	2	—
	(b) Other	10	48
13	Orthopaedic (a) Posture	16	18
	(b) Feet	29	33
	(c) Other	21	32
14	Nervous System (a) Epilepsy	13	9
	(b) Other	2	29
15	Psychological (a) Development	22	29
	(b) Stability	43	81
16	Abdomen	9	26
17	Other	54	20

PART III

TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

TABLE A.—EYE DISEASE, DEFECTIVE VISION AND SQUINT 1965

	Number of cases known to have been dealt with
External and Other, excluding errors of refraction and squint	196
Errors of Refraction (including squint)	4,206
TOTAL	4,402
Number of pupils for whom spectacles were prescribed	1,393

TABLE B.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	19
(b) for adenoids and chronic tonsilitis	80
(c) for other nose and throat conditions	9
Received other forms of treatment	49
TOTAL	157
Total number of pupils in schools who are known to have been provided with hearing aids—	
(a) in 1965	34
(b) in previous years	92

TABLE C.—ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases known to have been dealt with
(a) Pupils treated at clinics or out-patients departments	425
(b) Pupils treated at school for postural defects	41
TOTAL	466

TABLE D.—DISEASES OF THE SKIN

(excluding uncleanliness, for which see Table D part I)

	Number of cases known to have been dealt with
Ringworm (i) Scalp	—
(ii) Body	8
Scabies	8
Impetigo	93
Other skin diseases	60
TOTAL	169

TABLE E.—CHILD GUIDANCE TREATMENT

Pupils treated at child Guidance clinics	585

TABLE F.—SPEECH THERAPY

Pupils treated by Speech Therapists	432

TABLE G.—OTHER TREATMENT GIVEN

(a) Pupils with minor ailments	862
(b) Pupils who received convalescent treatment under School Health Service arrangements	—
(c) Pupils who received B.C.G. vaccination	4,068
TOTAL	4,930

PART IV 1965

DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY

Attendances and Treatment	Ages 5 to 9	10 to 14	15 and over	Total
First visit	3,450	2,391	355	6,196
Subsequent visit	4,681	3,799	622	9,102
Total visits	8,131	6,190	977	15,298
Additional courses of— Treatment commenced	75	43	7	125
Fillings in permanent teeth	1,980	3,418	685	6,083
Fillings in deciduous teeth	2,750	333	–	3,083
Permanent teeth filled	1,781	3,200	632	5,613
Deciduous teeth filled	2,619	323	–	2,942
Permanent teeth extracted	139	512	102	753
Deciduous teeth extracted	1,972	788	–	2,760
General anaesthetics	939	544	38	1,521
Emergencies	59	82	5	146
Number of pupils X-rayed				149
Prophylaxis				1,211
Teeth otherwise conserved				676
Number of teeth root filled				6
Inlays				1
Crowns				7
Courses of treatment completed				3,775
Orthodontics				
Cases remaining from previous year				73
New cases commenced during year				39
Cases completed during year				29
Cases discontinued during year				13
No. of removable appliances fitted				30
No. of fixed appliances fitted				1
Pupils referred to Hospital Consultant				6

PROSTHETICS

	Ages			
	5 to 9	10 to 14	15 and over	Total
Pupils supplied with F.U. or F.L. (first time) ..	—	—	—	—
Pupils supplied with other dentures (first time) ..	—	8	7	15
Number of dentures supplied	—	8	8	16

ANAESTHETICS

General Anaesthetics administered by Dental Offices ..	—

INSPECTIONS

(a) First inspection at school. Number of Pupils	36,351
(b) First inspection at clinic. Number of Pupils	314
Number of (a) and (b) found to require treatment	17,549
Number of (a) and (b) offered treatment	16,071
(c) Pupils re-inspected at School Clinic	175
Number of (c) found to require treatment	122

SESSIONS

Sessions devoted to treatment	2,606
Sessions devoted to Inspection	331
Sessions devoted to Dental Health Education	247

INDEX

COUNTY MEDICAL OFFICER

SCHOOL HEALTH SERVICE